PRINTED: 08/25/2017 FORM APPROVED

| CENTERS FO               | R MEDICARE & MEDIC                                                                                                                                         | CAID SERVICES                                                                                                                                                                                                                |                                   |                                                                                                             | ON                                      | ИВ NO. 0938-0391           |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------|
|                          | NT OF DEFICIENCIES  OF CORRECTION                                                                                                                          | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                     | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION  00                                                                                            | (X3) DATE SURVEY  COMPLETED  06/05/2017 |                            |
| NAME OF                  | PROVIDER OR SUPPLIEI                                                                                                                                       | R                                                                                                                                                                                                                            |                                   | T ADDRESS, CITY, STATE, ZIP CODE                                                                            | i .                                     |                            |
| AT HOM                   | IE HEALTH SERVIO                                                                                                                                           | CES LLC                                                                                                                                                                                                                      |                                   | E 82ND ST STE 216<br>ANAPOLIS, IN 46250                                                                     |                                         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                             | TATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)                                                                                                                                       | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | D BE                                    | (X5)<br>COMPLETION<br>DATE |
| G 0000                   |                                                                                                                                                            |                                                                                                                                                                                                                              |                                   |                                                                                                             |                                         |                            |
| Bldg. 00                 | This was a feder recertification w                                                                                                                         | rith complaint survey.                                                                                                                                                                                                       | G 0000                            |                                                                                                             |                                         |                            |
|                          | Survey Dates: N<br>5, 2017                                                                                                                                 | May 30, 31, June 1, 2, and                                                                                                                                                                                                   |                                   |                                                                                                             |                                         |                            |
|                          | Complaint numb<br>Substantiated; F<br>deficiencies wer                                                                                                     |                                                                                                                                                                                                                              |                                   |                                                                                                             |                                         |                            |
|                          | Facility Number                                                                                                                                            | r: 012383                                                                                                                                                                                                                    |                                   |                                                                                                             |                                         |                            |
|                          | Medicaid Numb                                                                                                                                              | per: 201005950A                                                                                                                                                                                                              |                                   |                                                                                                             |                                         |                            |
|                          | Census: 71                                                                                                                                                 |                                                                                                                                                                                                                              |                                   |                                                                                                             |                                         |                            |
|                          | Sample: 10                                                                                                                                                 |                                                                                                                                                                                                                              |                                   |                                                                                                             |                                         |                            |
|                          | from providing a<br>competency eva<br>period of 2 years<br>to June 5, 2019,<br>compliance with<br>Rights; 494.14 (<br>and Administrat<br>of Patients, Plan | a Services is precluded its own training and luation program for a s beginning June 5, 2017 for being found out of a the 484.10 Patient Organization, Services, ion; 484.18 Acceptance of Care, Medical 4.30 Skilled Nursing |                                   |                                                                                                             |                                         |                            |

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

Services; 484.36 Home Health Aide Services; 484.48 Clinical Records; and

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

012383

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                  | l í                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ULTIPLE CC<br>JILDING                                                                     | 00                  | (X3) DATE SURVEY  COMPLETED                                                                                   |        |                            |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------|--------|----------------------------|
|                                                                                                    |                                                                                                                                                                                                                                                                                                                                                  | 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | B. W                                                                                      | ING                 |                                                                                                               | 06/05/ | /2017                      |
|                                                                                                    | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                     |                                                                                                               |        |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                           | (EACH DEFICIEN<br>REGULATORY OR                                                                                                                                                                                                                                                                                                                  | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ensive Assessment of                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .ΤΕ    | (X5)<br>COMPLETION<br>DATE |
| G 0100<br>Bldg. 00                                                                                 |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           | 100                 | Soc C102 C109 C114                                                                                            |        | 00/25/2017                 |
|                                                                                                    | the agency failed documentation the patient a written in 1 out of 1 recorded readmitted to ser (See G103); failed and / or caregive advance of the diffurnish care, the provided, the antiduration of visits any changes in the discharged recorder in care and in 6 of 2016 and 2017 in 108); and failed or | nat it had provided a notice of patient rights ord reviewed of a patient vices in a sample of 10 ed to ensure the patient r were informed in isciplines that would type of care to be icipated frequency / to be provided and of neir care in 2 out of 2 ds reviewed of changes out of 6 admissions in n a sample of 10 (See G to inform the patient, ting, the charges for r not be covered and that ay have to pay for 6 of 6 l of patients admitted 2017 to current in a | G 0                                                                                       | 100                 | See G103, G108, G114                                                                                          |        | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 2 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  06/05/2017                                                                            |                                                                                     |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ETED                                            |                            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                                                             |                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TE                                              | (X5)<br>COMPLETION<br>DATE |
| G 0103<br>Bldg. 00                                                                                         | problem resulted of compliance where the compliance was a participation 482. The cumulative of problems resulted agency's inability of quality health environment.  484.10(a)(2) NOTICE OF RIGHTHE HHA must masshowing that it has requirements of the Based on record the agency failed documentation the patient a written in 1 out of 1 recording readmitted to ser (#6)  Findings included 1. The clinical record failed to eather the patient #6 has written notice of the patient #6 has written notic | ecord for patient #6, as reviewed. The clinical evidence documentation ad been provided with a formulation and been provided with a formulation and patient rights. | G 0                                                                                 | 103                 | Director of Nursing/designee vin-service all nursing staff on the need to provide patient/caregivith a copy of Patient Rights. (Complete 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on the need to provide patient/caregiver with a copy of Patient Rights. (To begin by 8/25/17) Director of Nursing/designee vindit 100% of Admissions to ensure compliance with documentation indicating patient/caregiver received cop Patient Rights. After 100% compliance is achieved, Direct of Nursing/designee will audit 25% of admissions monthly to | he<br>ver<br>ion<br>is<br>solif<br>vill<br>y of | 08/25/2017                 |
|                                                                                                            | A. The Dire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ector of Clinical Services                                                                                                                                          |                                                                                     |                     | 25% of admissions monthly to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                 |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 3 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | l í                                                   |      | DNSTRUCTION | (X3) DATE                                                                             |        |            |
|------------------------------------------------------|----------------------|-------------------------------------------------------|------|-------------|---------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:                                |      | UILDING     | 00                                                                                    | COMPL  |            |
|                                                      |                      | 15K064                                                | B. W | ING         |                                                                                       | 06/05/ | 2017       |
| NAME OF P                                            | ROVIDER OR SUPPLIER  |                                                       |      |             | ADDRESS, CITY, STATE, ZIP CODE                                                        |        |            |
|                                                      |                      |                                                       |      |             | 82ND ST STE 216                                                                       |        |            |
| AT HOMI                                              | E HEALTH SERVIC      | ES LLC                                                |      | INDIAN      | APOLIS, IN 46250                                                                      |        |            |
| (X4) ID                                              | SUMMARY S'           | TATEMENT OF DEFICIENCIES                              |      | ID          | PROVIDER'S PLAN OF CORRECTION                                                         |        | (X5)       |
| PREFIX                                               | ·                    | CY MUST BE PRECEDED BY FULL                           |      | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION)                          | _    | TAG         |                                                                                       |        | DATE       |
|                                                      |                      | on 6/5/17 at 9:45 a.m.                                |      |             | monitor compliance with documenting patient/caregive                                  | r      |            |
|                                                      |                      | e patient's certification                             |      |             | received copy of Patient Right                                                        |        |            |
|                                                      | •                    | ring a hospitalization and                            |      |             | (To begin by 8/25/17)                                                                 |        |            |
|                                                      |                      | old by their consultant                               |      |             | Director of Nursing/designee                                                          | will   |            |
|                                                      |                      | on paperwork did not                                  |      |             | train nursing staff on need to                                                        | 4:     |            |
|                                                      | _                    | ded or signatures                                     |      |             | readmit patient if their certification period ends while hospitalized                 |        |            |
|                                                      | obtained upon re     | eadmission.                                           |      |             | (To be done by 8/25/17)                                                               |        |            |
|                                                      | 2 An undated n       | olicy titled "Client                                  |      |             | The Director of Nursing will be<br>responsible for monitoring the                     |        |            |
|                                                      | •                    | ess" C- 140, indicated "                              |      |             | corrective actions to ensure the                                                      |        |            |
|                                                      |                      | ient with a copy of their                             |      |             | deficiency is corrected and wi                                                        |        |            |
|                                                      |                      | d the Notice of privacy                               |      |             | not recur.                                                                            |        |            |
|                                                      |                      |                                                       |      |             |                                                                                       |        |            |
|                                                      |                      | tain consent to use and                               |      |             |                                                                                       |        |            |
|                                                      | -                    | d health information for                              |      |             |                                                                                       |        |            |
|                                                      |                      | ent and healh care                                    |      |             |                                                                                       |        |            |
|                                                      | •                    | vide the client / caregiver                           |      |             |                                                                                       |        |            |
|                                                      |                      | an explaination of the                                |      |             |                                                                                       |        |            |
|                                                      | Home Care Bill       | •                                                     |      |             |                                                                                       |        |            |
|                                                      |                      | and the procedures for                                |      |             |                                                                                       |        |            |
|                                                      |                      | nt. This includes the                                 |      |             |                                                                                       |        |            |
|                                                      |                      | vacy Rights related to the                            |      |             |                                                                                       |        |            |
|                                                      |                      | ansmission of personal                                |      |             |                                                                                       |        |            |
|                                                      |                      | mation Obtain the                                     |      |             |                                                                                       |        |            |
|                                                      | client's signature   |                                                       |      |             |                                                                                       |        |            |
|                                                      | _                    | ne Care Bill of Rights,                               |      |             |                                                                                       |        |            |
|                                                      | and other forms      | required by the agency                                |      |             |                                                                                       |        |            |
|                                                      | "                    |                                                       |      |             |                                                                                       |        |            |
|                                                      |                      |                                                       |      |             |                                                                                       |        |            |
| G 0108                                               | 484.10(c)(1)         |                                                       |      |             |                                                                                       |        |            |
|                                                      | RIGHT TO BE INF      | FORMED AND                                            |      |             |                                                                                       |        |            |
| Bldg. 00                                             | PARTICIPATE          |                                                       |      |             |                                                                                       |        |            |
|                                                      |                      | e right to be informed, in                            |      |             |                                                                                       |        |            |
|                                                      |                      | e care to be furnished, and the care to be furnished. |      |             |                                                                                       |        |            |
|                                                      | or arry orializes in | and date to be fulfillation.                          |      |             |                                                                                       |        |            |
|                                                      | l                    |                                                       | 1    |             |                                                                                       |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 4 of 247

| STATEMEN  | NT OF DEFICIENCIES                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |                              |                                                                     | (X3) DATE SURVEY |            |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------|------------------------------|---------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                                                                                                                                                                                                         | IDENTIFICATION NUMBER:       | A. BU                      | JILDING                      | 00                                                                  | COMPI            | ETED       |
|           |                                                                                                                                                                                                                       | 15K064                       | B. W                       | ING                          |                                                                     | 06/05            | /2017      |
|           |                                                                                                                                                                                                                       | <u> </u>                     |                            | STREET                       | ADDRESS, CITY, STATE, ZIP CODE                                      |                  |            |
| NAME OF I | PROVIDER OR SUPPLIEF                                                                                                                                                                                                  | 8                            |                            |                              | 82ND ST STE 216                                                     |                  |            |
| AT HOM    | E HEALTH SERVIC                                                                                                                                                                                                       | CES LLC                      |                            |                              | IAPOLIS, IN 46250                                                   |                  |            |
| (X4) ID   | SUMMARY S                                                                                                                                                                                                             | TATEMENT OF DEFICIENCIES     |                            | ID                           | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |
| PREFIX    | (EACH DEFICIEN                                                                                                                                                                                                        | ICY MUST BE PRECEDED BY FULL |                            | PREFIX                       | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE              | COMPLETION |
| TAG       |                                                                                                                                                                                                                       | LSC IDENTIFYING INFORMATION) |                            | TAG                          | DEFICIENCY)                                                         |                  | DATE       |
|           |                                                                                                                                                                                                                       | lvise the patient in advance |                            |                              |                                                                     |                  |            |
|           | of the disciplines that will furnish care, and the frequency of visits proposed to be                                                                                                                                 |                              |                            |                              |                                                                     |                  |            |
|           | •                                                                                                                                                                                                                     | risits proposed to be        |                            |                              |                                                                     |                  |            |
|           | furnished.                                                                                                                                                                                                            |                              |                            |                              |                                                                     |                  |            |
|           | The HHA must ad                                                                                                                                                                                                       | lvise the patient in advance |                            |                              |                                                                     |                  |            |
|           | of any change in the plan of care before the change is made.  Based on record review and interview, the agency failed to ensure the patient and / or caregiver were informed in advance of the disciplines that would |                              |                            |                              |                                                                     |                  |            |
|           |                                                                                                                                                                                                                       |                              | G 0                        | 108                          | Director of Nursing will in-serv                                    |                  | 08/25/2017 |
|           |                                                                                                                                                                                                                       |                              |                            |                              | nurses on reviewing ordered a                                       | aide             |            |
|           |                                                                                                                                                                                                                       |                              |                            |                              | hours and comparing to what                                         |                  |            |
|           |                                                                                                                                                                                                                       |                              |                            |                              | hours aides are actually providing. If aide hours are               |                  |            |
|           |                                                                                                                                                                                                                       | type of care to be           | 1 1 1                      |                              | consistently below the maxim                                        | um               |            |
|           | provided, the anticipated frequency / duration of visits to be provided and of                                                                                                                                        |                              |                            |                              | ordered hours, nurse will talk                                      |                  |            |
|           |                                                                                                                                                                                                                       |                              |                            |                              | patient/caregiver about                                             |                  |            |
|           |                                                                                                                                                                                                                       | heir care in 2 out of 2      |                            |                              | decreasing hours, notify MD a                                       |                  |            |
|           |                                                                                                                                                                                                                       | ds reviewed of changes       |                            |                              | obtain verbal order for new aid frequency based on patient's        | ue               |            |
|           |                                                                                                                                                                                                                       | (0) and in 6 out of 6        |                            |                              | actual needs. (To be done by                                        |                  |            |
|           | ,                                                                                                                                                                                                                     | 016 and 2017 in a sample     |                            |                              | 8/2517)                                                             |                  |            |
|           |                                                                                                                                                                                                                       | •                            |                            |                              | Director of Nursing will be                                         |                  |            |
|           | of 10. (#3, 4, 5,                                                                                                                                                                                                     | 6, 8 and 9)                  |                            |                              | responsible to ensure orientat                                      |                  |            |
|           | E' 1' ' 1 1                                                                                                                                                                                                           |                              |                            |                              | of newly hired nurses includes training nurses on reviewing         | 5                |            |
|           | Findings include                                                                                                                                                                                                      | 2.                           |                            |                              | ordered aide hours and                                              |                  |            |
|           |                                                                                                                                                                                                                       |                              |                            |                              | comparing to what hours aide                                        | s                |            |
|           |                                                                                                                                                                                                                       | record for patient #1 SOC    |                            |                              | are actually providing. If aide                                     |                  |            |
|           |                                                                                                                                                                                                                       | 10/15, was reviewed and      |                            |                              | hours are consistently below t                                      |                  |            |
|           | included a writte                                                                                                                                                                                                     | en plan of care for the      |                            |                              | maximum ordered hours, nurs                                         | se               |            |
|           | certification of 5                                                                                                                                                                                                    | 5/9/15 to 7/7/15, with       |                            |                              | will talk with patient/caregiver about decreasing hours, notify     | ,                |            |
|           | orders for home                                                                                                                                                                                                       | health aide services up to   |                            |                              | MD and obtain verbal order for                                      |                  |            |
|           | 10 hours a day 7                                                                                                                                                                                                      | days a week to assist        |                            |                              | new aide frequency based on                                         |                  |            |
|           | 1                                                                                                                                                                                                                     | hygiene, transfers,          |                            |                              | patient's actual needs. (To be                                      | gin              |            |
|           |                                                                                                                                                                                                                       | nders, meal preparation /    |                            |                              | by 8/25/17)                                                         |                  |            |
|           |                                                                                                                                                                                                                       | housekeeping. The            |                            |                              | Director of Nursing/designee audit, weekly, 100% of aide n          |                  |            |
|           | 1 .                                                                                                                                                                                                                   | . •                          |                            |                              | and compare utilized frequence                                      |                  |            |
|           | patient had a diagnosis of Multiple Sclerosis.                                                                                                                                                                        |                              |                            | with MD ordered frequency to |                                                                     |                  |            |
|           | Scierosis.                                                                                                                                                                                                            | •                            |                            |                              | ensure compliance with havin                                        |                  |            |
|           |                                                                                                                                                                                                                       |                              |                            |                              | MD order that meets the patie                                       | -                |            |

| STATEMEN      | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION |           |                                                                        | (X3) DATE SURVEY |            |
|---------------|------------------------------------------------------|------------------------------|----------------------------|-----------|------------------------------------------------------------------------|------------------|------------|
| AND PLAN      | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU                      | JILDING   | 00                                                                     | COMPLI           | ETED       |
|               |                                                      | 15K064                       | B. W                       | NG        |                                                                        | 06/05/2          | 2017       |
|               |                                                      |                              |                            | CTD FFT A | ADDRESS CITY STATE ZIR CODE                                            |                  |            |
| NAME OF I     | PROVIDER OR SUPPLIEF                                 | 8                            |                            |           | ADDRESS, CITY, STATE, ZIP CODE                                         |                  |            |
| A.T. L. C. M. | E 11E A1 T11 0ED) //0                                | 250110                       |                            |           | 82ND ST STE 216                                                        |                  |            |
| AT HOM        | E HEALTH SERVIC                                      | JES LLC                      |                            | INDIAN    | APOLIS, IN 46250                                                       |                  |            |
| (X4) ID       | SUMMARY S                                            | TATEMENT OF DEFICIENCIES     |                            | ID        | PROVIDER'S PLAN OF CORRECTION                                          |                  | (X5)       |
| PREFIX        | (EACH DEFICIEN                                       | CY MUST BE PRECEDED BY FULL  |                            | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG           | REGULATORY OR                                        | LSC IDENTIFYING INFORMATION) |                            | TAG       | DEFICIENCY)                                                            |                  | DATE       |
|               | A. Review                                            | of the payroll time          |                            |           | actual aide needs. Once 100%                                           | ò                |            |
|               |                                                      | ne health aides were         |                            |           | compliance is achieved Directo                                         | or               |            |
|               | ·                                                    | es up from 5 to 7 hours a    |                            |           | of Nursing/designee will audit                                         |                  |            |
|               | 1 .                                                  | es up from 5 to 7 flours a   |                            |           | 25% of aide notes monthly and                                          |                  |            |
|               | day.                                                 |                              |                            |           | compare utilized frequency wit                                         |                  |            |
|               |                                                      |                              |                            |           | MD ordered frequency to ensu                                           |                  |            |
|               | B. Review                                            | of the FSSA (Family          |                            |           | compliance with having MD or that meets patient's actual nee           |                  |            |
|               | Social Service A                                     | dministration) Medicaid      |                            |           | (To begin by 8/25/17)                                                  | us.              |            |
|               | paperwork dated                                      | 1 6/2/15, indicated the      |                            |           | Director of Nursing will in-servi                                      | <sub>ice</sub>   |            |
|               |                                                      | prior authorization          |                            |           | nurses on need to notify patier                                        |                  |            |
|               | -                                                    | lified and that the          |                            |           | caregiver if Medicaid decrease                                         |                  |            |
|               | _                                                    |                              |                            |           | number of hours requested on                                           |                  |            |
|               | _                                                    | were excessie based on       |                            |           | the PA, obtain MD order for the                                        | e                |            |
|               | the medical docu                                     | umentation submitted.        |                            |           | hours approved by Medicaid a                                           |                  |            |
|               |                                                      |                              |                            |           | document in patient chart. (To                                         | be               |            |
|               | C. Review                                            | of the FSSA Medicaid         |                            |           | done by 8/25/17)                                                       |                  |            |
|               | nanerwork dated                                      | 1 6/17/15, indicated the     |                            |           | Director of Nursing/designee v                                         | vill             |            |
|               |                                                      | se the home health aide      |                            |           | be responsible to ensure                                               |                  |            |
|               | _                                                    | enied as medically not       |                            |           | orientation of newly hired nurs includes training on need to no        |                  |            |
|               |                                                      | ined as medicarry not        |                            |           | patient / caregiver if Medicaid                                        | July             |            |
|               | necessary.                                           |                              |                            |           | decreases number of hours                                              |                  |            |
|               |                                                      |                              |                            |           | requested on the PA, obtain M                                          | iD               |            |
|               | D. Review                                            | of the communications        |                            |           | order for any decrease in the                                          |                  |            |
|               | notes dated 6/15                                     | /15, 6/18/15, 7/5/15 and     |                            |           | hours approved by Medicaid a                                           | nd               |            |
|               | a nursing visit or                                   | n 6/30/15, the agency        |                            |           | document in patient chart. (To                                         |                  |            |
|               | _                                                    | te that the patient and / or |                            |           | begin by 8/25/17)                                                      |                  |            |
|               |                                                      | formed of Medicaid's         |                            |           | Director of Nursing/designee w                                         | vill             |            |
|               |                                                      |                              |                            |           | audit, weekly, all Medicaid                                            |                  |            |
|               |                                                      | ease the home health aide    |                            |           | authorizations received. If                                            | ,                |            |
|               |                                                      | making a change in the       |                            |           | Medicaid decreased requested hours, Director of                        | ۱                |            |
|               | agency's ability                                     | to service the patient.      |                            |           | Nursing/designee will ensure                                           |                  |            |
|               |                                                      |                              |                            |           | there is documentation                                                 |                  |            |
|               | 2. The clinical r                                    | record number 3, SOC         |                            |           | patient/caregiver was notified                                         | of               |            |
|               |                                                      | /28/16, was reviewed.        |                            |           | the decrease and MD order wa                                           |                  |            |
|               | ,                                                    | ord failed to evidence that  |                            |           | obtained for authorized                                                |                  |            |
|               |                                                      |                              |                            |           | frequency. Once 100%                                                   |                  |            |
|               | _                                                    | egiver was informed and      |                            |           | compliance is achieved, Direct                                         | tor              |            |
|               |                                                      | ce of the disciplines that   |                            |           | of Nursing/designee will audit,                                        |                  |            |
|               | will furnish care                                    | , the type of care to be     |                            |           | monthly, 25% of Medicaid                                               |                  |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                  | (X2) MULTIPLE CONSTRUCTION   |       |          | (X3) DATE SURVEY                                                    |        |            |
|------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------|-------|----------|---------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                    | IDENTIFICATION NUMBER:       | A. BU | JILDING  | 00                                                                  | COMPL  | ETED       |
|                                                      |                                                                                  | 15K064                       | B. W  | NG       |                                                                     | 06/05/ | 2017       |
|                                                      |                                                                                  |                              |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                      |        |            |
| NAME OF F                                            | PROVIDER OR SUPPLIER                                                             |                              |       |          | 82ND ST STE 216                                                     |        |            |
| AT HOM                                               | E HEALTH SERVIC                                                                  | ESTIC                        |       |          | APOLIS, IN 46250                                                    |        |            |
| ATTIONI                                              | E HEALTH SERVIC                                                                  |                              |       | INDIAN   | AFOLIS, IN 40250                                                    |        |            |
| (X4) ID                                              | SUMMARY S                                                                        | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                               | l `                                                                              | CY MUST BE PRECEDED BY FULL  |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE     | COMPLETION |
| TAG                                                  | REGULATORY OR                                                                    | LSC IDENTIFYING INFORMATION) |       | TAG      | DEFICIENCY)                                                         |        | DATE       |
|                                                      | provided, and the                                                                | e anticipated frequency /    |       |          | authorizations received that                                        |        |            |
|                                                      | duration of visits                                                               | s to be provided.            |       |          | month to ensure compliance w                                        |        |            |
|                                                      |                                                                                  |                              |       |          | notifying patient/caregiver of a decrease in hours approved a       | -      |            |
|                                                      | 3 The clinical r                                                                 | ecord number 4, SOC          |       |          | MD order obtained for authoriz                                      |        |            |
|                                                      | 4/24/16, was reviewed. The clinical record failed to evidence that the patient / |                              |       |          | frequency. (To begin by 8/25/1                                      |        |            |
|                                                      |                                                                                  |                              |       |          | Director of Nursing will in-servi                                   |        |            |
|                                                      |                                                                                  |                              |       |          | nursing staff on documenting,                                       |        |            |
|                                                      | ~                                                                                | formed and agreed in         |       |          | time of admission, that                                             |        |            |
|                                                      |                                                                                  | isciplines that will         |       |          | patient/caregiver was notified                                      |        |            |
|                                                      | furnish care, the                                                                | type of care to be           |       |          | disciplines to be provided, type                                    | e of   |            |
|                                                      | provided, and the                                                                | e anticipated frequency /    |       |          | care to be provided, and                                            | _      |            |
|                                                      | duration of visits                                                               | s to be provided.            |       |          | frequency/duration of visits. (T be completed by 8/25/17)           | O      |            |
|                                                      |                                                                                  | •                            |       |          | Director of Nursing will be                                         |        |            |
|                                                      | 4 The clinical r                                                                 | ecord for patient #5,        |       |          | responsible to ensure orientati                                     | on     |            |
|                                                      |                                                                                  | vas reviewed. The            |       |          | of newly hired nurses includes                                      |        |            |
|                                                      | · · · · · · · · · · · · · · · · · · ·                                            |                              |       |          | training on documenting, at tim                                     |        |            |
|                                                      |                                                                                  | niled to evidence that the   |       |          | of admission, that                                                  |        |            |
|                                                      |                                                                                  | er was informed and          |       |          | patient/caregiver was notified                                      |        |            |
|                                                      | agreed in advanc                                                                 | ee of the disciplines that   |       |          | disciplines to be provided, type                                    | e of   |            |
|                                                      | will furnish care                                                                | , the type of care to be     |       |          | care to be provided, and                                            | _      |            |
|                                                      | provided, and the                                                                | e anticipated frequency /    |       |          | frequency/duration of visits. (T begin by 8/25/17)                  | O      |            |
|                                                      | duration of visits                                                               | s to be provided.            |       |          | Director of Nursing/designee v                                      | /ill   |            |
|                                                      |                                                                                  | •                            |       |          | audit 100% of admissions to                                         |        |            |
|                                                      | 5 The clinical r                                                                 | ecord for patient #6,        |       |          | ensure compliance with                                              |        |            |
|                                                      |                                                                                  | as reviewed. The clinical    |       |          | documenting, at time of                                             |        |            |
|                                                      | · ·                                                                              |                              |       |          | admission, that patient/caregiv                                     | -      |            |
|                                                      |                                                                                  | evidence that the patient /  |       |          | was notified of disciplines to be                                   | Э      |            |
|                                                      |                                                                                  | formed and agreed in         |       |          | provided, type of care to be                                        |        |            |
|                                                      | advance of the d                                                                 | isciplines that will         |       |          | provided, and frequency/durat                                       |        |            |
|                                                      | furnish care, the                                                                | type of care to be           |       |          | of visits. (To begin by 8/25/17) Director of Nursing will in-servi  |        |            |
|                                                      | provided, and the                                                                | e anticipated frequency /    |       |          | nursing staff on requirement to                                     |        |            |
|                                                      | duration of visits                                                               |                              |       |          | notify MD of a patient's discha                                     |        |            |
|                                                      |                                                                                  | 1                            |       |          | notify patient/caregiver of                                         | - '    |            |
|                                                      | 6 The clinical r                                                                 | ecord for patient #8,        |       |          | discharge at least fifteen (15)                                     |        |            |
|                                                      |                                                                                  | •                            |       |          | days before discharge and                                           |        |            |
|                                                      |                                                                                  | s reviewed. The clinical     |       |          | notifying any other agency                                          |        |            |
|                                                      |                                                                                  | evidence that the patient /  |       |          | involved in patient's care of                                       |        |            |
|                                                      | caregiver was in                                                                 | formed and agreed in         | 1     |          | upcoming discharge of patient                                       |        |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                      | (X2) MULTIPLE CONSTRUCTION   |       |          | (X3) DATE SURVEY                                                       |        |            |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------|-------|----------|------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                        | IDENTIFICATION NUMBER:       | A. BU | JILDING  | 00                                                                     | COMPL  | ETED       |
|                                                      |                                                                                                                      | 15K064                       | B. WI | ING      |                                                                        | 06/05/ | 2017       |
|                                                      |                                                                                                                      |                              |       | CTDEET / | ADDRESS, CITY, STATE, ZIP CODE                                         |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                                                                                 | 8                            |       |          | 82ND ST STE 216                                                        |        |            |
| AT LIONA                                             |                                                                                                                      | SEC LL C                     |       |          |                                                                        |        |            |
| AT HOW                                               | E HEALTH SERVIC                                                                                                      | JES LLC                      |       | INDIAN   | APOLIS, IN 46250                                                       |        |            |
| (X4) ID                                              | SUMMARY S                                                                                                            | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX                                               |                                                                                                                      | CY MUST BE PRECEDED BY FULL  |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                  | REGULATORY OR                                                                                                        | LSC IDENTIFYING INFORMATION) |       | TAG      | DEFICIENCY)                                                            |        | DATE       |
|                                                      | advance of the d                                                                                                     | isciplines that will         |       |          | from agency. Nurses to docur                                           |        |            |
|                                                      | furnish care, the                                                                                                    | type of care to be           |       |          | these conversations in patient                                         | .'S    |            |
|                                                      | provided, and the anticipated frequency / duration of visits to be provided.  7. The clinical record for patient #9, |                              |       |          | chart. (To be completed by                                             |        |            |
|                                                      |                                                                                                                      |                              |       |          | 8/25/17) Director of Nursing will be                                   |        |            |
|                                                      |                                                                                                                      |                              |       |          | responsible to ensure orientat                                         | ion    |            |
|                                                      |                                                                                                                      |                              |       |          | of newly hired nurses includes                                         |        |            |
|                                                      |                                                                                                                      |                              |       |          | training on requirement to not                                         |        |            |
|                                                      | -                                                                                                                    | s reviewed. The clinical     |       |          | MD of a patient's discharge, n                                         | -      |            |
|                                                      |                                                                                                                      | evidence that the patient /  |       |          | patient/caregiver of discharge                                         | at     |            |
|                                                      | caregiver was in                                                                                                     | formed and agreed in         |       |          | least fifteen (15) days before                                         |        |            |
|                                                      | advance of the d                                                                                                     | isciplines that will         |       |          | discharge and notifying any of                                         |        |            |
|                                                      | furnish care, the                                                                                                    | type of care to be           |       |          | agency involved in patient's ca<br>of upcoming discharge of patients   |        |            |
|                                                      | provided, and the anticipated frequency /                                                                            |                              |       |          | from agency. Nurses to docum                                           |        |            |
|                                                      | duration of visits                                                                                                   |                              |       |          | these conversations in patient                                         |        |            |
|                                                      | duration of visit                                                                                                    | s to be provided.            |       |          | chart. (To begin by 8/25/17)                                           |        |            |
|                                                      | 0 751 1: 1                                                                                                           | 16 //10 600 ( )              |       |          | Director of Nursing/designee v                                         | will   |            |
|                                                      |                                                                                                                      | ecord for #10, SOC (start    |       |          | audit 100% of discharges to                                            |        |            |
|                                                      |                                                                                                                      | was reviewed and             |       |          | ensure compliance with notify                                          | ing    |            |
|                                                      | included a plan of                                                                                                   | of care for the              |       |          | MD of upcoming discharge,                                              |        |            |
|                                                      | certification of 3                                                                                                   | /7/17 to 5/5/17, with        |       |          | notifying patient of discharge                                         | at     |            |
|                                                      | orders for home                                                                                                      | health aide services up to   |       |          | least fifteen (15) days before discharge and notifying other           |        |            |
|                                                      |                                                                                                                      | lays a week to assist with   |       |          | agencies involved in patient's                                         |        |            |
|                                                      | _                                                                                                                    | athing, dressing, activities |       |          | care of patient's upcoming                                             |        |            |
|                                                      | _                                                                                                                    | neal prep, medication        |       |          | discharge from agency. (To be                                          | egin   |            |
|                                                      | 1 2                                                                                                                  | ght housekeeping per         |       |          | by 8/25/17)                                                            |        |            |
|                                                      |                                                                                                                      | gnt nousekeeping per         |       |          | The Director of Nursing will be                                        |        |            |
|                                                      | care plan.                                                                                                           |                              |       |          | responsible for monitoring these                                       | 9      |            |
|                                                      |                                                                                                                      |                              |       |          | corrective actions to ensure that                                      | :      |            |
|                                                      | A. The clin                                                                                                          | ical record evidenced a      |       |          | this deficiency is corrected and                                       |        |            |
|                                                      | discharge OASI                                                                                                       | S discharge assessment       |       |          | will not recur.                                                        |        |            |
|                                                      | dated 4/2/17. Th                                                                                                     | ne clinical record failed    |       |          |                                                                        |        |            |
|                                                      | to evidenced tha                                                                                                     | t the attending physician    |       |          |                                                                        |        |            |
|                                                      |                                                                                                                      | d in advance of the          |       |          |                                                                        |        |            |
|                                                      |                                                                                                                      | duled discharge, the         |       |          |                                                                        |        |            |
|                                                      | _                                                                                                                    | _                            |       |          |                                                                        |        |            |
|                                                      | -                                                                                                                    | informed in advance of       |       |          |                                                                        |        |            |
|                                                      | _                                                                                                                    | d failed to provide          |       |          |                                                                        |        |            |
|                                                      | I documentation in                                                                                                   | n regards notifying the      |       |          |                                                                        |        |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                           | (X2) MULTIPLE ( A. BUILDING B. WING                                                                                                                                                               | CONSTRUCTION  00                                                                          | COM                                                                                                         | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |  |
|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|--|
|                                                                                                            | PROVIDER OR SUPPLIEI                                                                                      |                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                             |                                       |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                            | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | O BE                                  | (X5)<br>COMPLETION<br>DATE |  |
|                                                                                                            |                                                                                                           | th agency and verifying ces being provided.                                                                                                                                                       |                                                                                           |                                                                                                             |                                       |                            |  |
|                                                                                                            | C, Interim Direction 5/31/17 at 2:: indicated the part and indicated an agency was in the Health Services | view with the Employee stor of Clinical Services, 30 p.m., the employee stient notified the agency other home health he home. At Home decided to discharge the ployee indicated a 15 day rovided. |                                                                                           |                                                                                                             |                                       |                            |  |
|                                                                                                            | Employee C wa                                                                                             | /17 at 2:30 p.m., s not unable to provide mentation upon request.                                                                                                                                 |                                                                                           |                                                                                                             |                                       |                            |  |
|                                                                                                            | Services and En<br>Assistant Direct<br>had no further in                                                  | n relation to the above                                                                                                                                                                           |                                                                                           |                                                                                                             |                                       |                            |  |
|                                                                                                            | further informat                                                                                          | A, the Alternate and Employee B, had no ion or documentation by ace on 6/5/17 at 3:50 p.m.                                                                                                        |                                                                                           |                                                                                                             |                                       |                            |  |
|                                                                                                            | Admission Proc<br>Review the pl<br>treatment, and c                                                       | policy titled "Client<br>ess" C- 140, indicated "<br>an for services,<br>are with the client /<br>reasonable risk and / or                                                                        |                                                                                           |                                                                                                             |                                       |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 9 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                         | JILDING                                                                                   | 00                  | COMPLI<br>06/05/2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ETED                                         |                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------|
| NAME OF PROVIDER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                            |
| TAG REG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ACH DEFICIEN<br>ULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ted with any procedure nome "                                                                                                                         |                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TE                                           | (X5)<br>COMPLETION<br>DATE |
| Bldg. 00  Before inform (i) The expect other find known (ii) The covere (iii) The covere (iii) The to pay Based agence and in that me indivisite record between sample Findin 1. The SOC Admit 11/28 100% and / 6 and | the care is the patient, extent to we ded from Me Federally fur to the HHA extended by Medical charges to a writing, the dual may have been 2016 to be of 10. (### mgs included to the clinical resistance of 1/28/16, version Service of the covered at the covered | or services that will not be are; and not the individual may have all record review, the inform the patient, orally ne charges for services covered and that the nave to pay for 6 of 6 d of patients admitted 2017 to current in a 43) | G 0                                                                                       | 114                 | Director of Nursing will in-serv nursing staff on ensuring patient/caregiver is informed, verbally and in writing at the time of admission, of the cost of services to be provided should the payer not cover services. be done by 8/25/17)  Director of Nursing will be responsible to ensure orientation of new nurses includes training on making sure patient/caregivis informed, verbally and in wrat the time of admission, of the cost of services to be provided should the payer not cover charges. (To begin by 8/25/17) The agency has revised Servic Agreement to include "estimat cost per visit." (Completed 8/7 (See Attachment A)  Director of Nursing will in-serv nursing staff on how to complete | me d (To ion g ver iting e d 7) ce eed 7/17) | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 10 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                        | (X2) M                       | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |            |
|------------------------------------------------------|------------------------------------------------------------------------|------------------------------|------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| AND PLAN                                             | OF CORRECTION                                                          | IDENTIFICATION NUMBER:       | A. BU      | ЛLDING      | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | COMPLETED  |
|                                                      |                                                                        | 15K064                       | B. W       | ING         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 06/05/2017 |
|                                                      |                                                                        | <u> </u>                     |            | STREET A    | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
| NAME OF P                                            | PROVIDER OR SUPPLIEF                                                   | ₹                            |            |             | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
| AT HOMI                                              | E HEALTH SERVIC                                                        | CES LLC                      |            |             | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |            |
| (X4) ID                                              | SUMMARY S                                                              | TATEMENT OF DEFICIENCIES     |            | ID          | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X5)       |
| PREFIX                                               | `                                                                      | ICY MUST BE PRECEDED BY FULL |            | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |            |
| TAG                                                  |                                                                        | LSC IDENTIFYING INFORMATION) | _          | TAG         | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | DATE       |
|                                                      |                                                                        | ered by the insurance        |            |             | cost of service to be provided                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | and        |
|                                                      | benefit.                                                               |                              |            |             | marking the correct payer. (Complete 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |
|                                                      | 2. The clinical record number 4, SOC                                   |                              |            |             | Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |            |
|                                                      |                                                                        |                              |            |             | responsible to ensure orientati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | on         |
|                                                      | 4/24/16, was rev                                                       | riewed. The Admission        |            |             | of newly hired nurses includes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
|                                                      | Service Agreem                                                         | ent dated 4/24/17, failed    |            |             | training on how to complete th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
|                                                      |                                                                        | iability for payment and     |            |             | form appropriately. (To begin | Dy         |
|                                                      |                                                                        | may occur for services       |            |             | 8/25/17) Director of Nursing/designee v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | vill       |
|                                                      | ı                                                                      | he insurance benefit.        |            |             | audit all admissions to monitor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | not covered by the insurance benefit.                                  |                              |            |             | compliance with documenting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |            |
|                                                      | 3 The clinical r                                                       | ecord for nationt #5         |            |             | patient/caregiver were informe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
|                                                      | 3. The clinical record for patient #5, SOC 11/21/16, was reviewed. The |                              |            |             | verbally and in writing at the til                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |            |
|                                                      | 1                                                                      | ice Agreement dated          |            |             | of admission, of cost of service should payer not cover service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        | _                            |            |             | and that the service agreemen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |
|                                                      |                                                                        | eare as the liability of     |            |             | has been completed appropria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |
|                                                      | * *                                                                    | gency provided Medicaid      |            |             | - listing the cost of service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |
|                                                      |                                                                        | ices. The Admission          |            |             | provided and correct payer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |
|                                                      | _                                                                      | ent failed to evidence the   |            |             | marked. (To begin 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            |
|                                                      | 1                                                                      | ect liability of payment     |            |             | The Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        | lude charges that may        |            |             | responsible for monitoring these                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |            |
|                                                      |                                                                        | es not covered by the        |            |             | corrective actions to ensure that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |            |
|                                                      | insurance benefi                                                       | t.                           |            |             | this deficiency is corrected and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |            |
|                                                      |                                                                        |                              |            |             | will not recur.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | 4. The clinical r                                                      | record for patient #6,       |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | SOC 1/30/17, w                                                         | as reviewed. The clinical    |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | record failed to                                                       | evidence an Admission        |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | Service Agreem                                                         | ent.                         |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        |                              |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | A. The Dire                                                            | ector of Clinical Services   |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        | on 6/5/17 at 9:45 a.m.       |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        | e patient's certification    |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        | ring a hospitalization and   |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | _                                                                      | told by their consultant     |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        |                              |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      |                                                                        | ion paperwork did not        |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |
|                                                      | need to be provi                                                       | ded or signatures            |            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |            |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN                 | AND PLAN OF CORRECTION IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. BU | A. BUILDING 00  B. WING |                                                                                                                         |    | COMPLETED 06/05/2017       |  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------------------------|-------------------------------------------------------------------------------------------------------------------------|----|----------------------------|--|
| NAME OF I                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |       |                         | DDRESS, CITY, STATE, ZIP CODE                                                                                           |    |                            |  |
| AT HOM                   | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                         | 82ND ST STE 216<br>APOLIS, IN 46250                                                                                     |    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                             |       | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |  |
|                          | SOC 8/3/16, was Admission Servi 8/3/16, indicated 100% covered at and / or other red Admission Servi evidence the chaservices not cover benefit.  6. The clinical respectively some services of the services o | ecord for patient #8, reviewed. The ce Agreement dated "Medicaid (Project for meeting spend down quirements)." The ce Agreement failed to rges that may occur for ered by the insurance  ecord for patient #9, reviewed. The ce Agreement dated "Medicaid (Project for meeting spend down quirements)." The ce Agreement failed to rges that may occur for ered by the insurance  the Director of Clinical ployee C, the Interim or of Clinical Services, formation or n relation to the above 7 at 4:00 p.m. |       |                         |                                                                                                                         |    |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 12 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE A. BUILDING B. WING                                                 | CONSTRUCTION  00                                                                    | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                 |                      |  |  |  |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------|--|--|--|
|                                                                                                             | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                       |                      |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                             | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | (X5) COMPLETION DATE |  |  |  |
| G 0122<br>Bldg. 00                                                                                          | 9. An undated p Admission Proce Advise the clic charges and billi extent possible, to coverage, the cli liability, and oth Explain the conc benefits and the received from th the agency's serv informed of any obligations related  484.14 ORGANIZATION, ADMINISTRATION Based on record the Administrate clinical staff ann evaluations were months in 2 out of reviewed (See G that their efforts effectively with a serving their pati- | N<br>review and interview,<br>or failed to ensure that                            | G 0122                                                                              | See G134, G143, G145, G14                                                                                             | 17 08/25/2017        |  |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 13 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                              | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                 | l í | UILDING             | NSTRUCTION  00                                                                                                         | (X3) DATE :<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
| NAME OF F                | ROVIDER OR SUPPLIER                                                                                                                                                              |                                                                                                                                                                                                                                                                                                          |     |                     | DDRESS, CITY, STATE, ZIP CODE<br>32ND ST STE 216                                                                       |                                |                            |
| AT HOMI                  | E HEALTH SERVIC                                                                                                                                                                  | ES LLC                                                                                                                                                                                                                                                                                                   |     | INDIANA             | APOLIS, IN 46250                                                                                                       |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                   | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                        |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE                            | (X5)<br>COMPLETION<br>DATE |
|                          | active records re (See G 144); fail summaries were progress towards being met for 4 creviewed of patic in a sample of 10 to ensure that an budget that included budget and capit | eatient care in 8 out of 8 viewed in a sample of 10 ed to ensure 60 day reflective of the patients is goals being met and not out of 7 active records ents with recertifications 0 (See G 145); and failed overall plan and a ded annual operating all expenditure was equest for 1 of 1 home ee G 147). |     |                     |                                                                                                                        |                                |                            |
|                          | problem resulted<br>of compliance w                                                                                                                                              | effect of this systemic<br>in the agency being out<br>ith the Condition of<br>1.14 Organization,<br>ninistration.                                                                                                                                                                                        |     |                     |                                                                                                                        |                                |                            |
|                          | problems resulte                                                                                                                                                                 | effect of these systemic<br>d in the home health<br>y to ensure te provision<br>care in a safe                                                                                                                                                                                                           |     |                     |                                                                                                                        |                                |                            |
| G 0134<br>Bldg. 00       | supervising physic<br>required under pa<br>employs qualified                                                                                                                     | R who may also be the sian or registered nurse ragraph (d) of this section, personnel and ensures ucation and evaluations.                                                                                                                                                                               |     |                     |                                                                                                                        |                                |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 14 of 247

| STATEMEN  | IT OF DEFICIENCIES                | X1) PROVIDER/SUPPLIER/CLIA                  | CLIA (X2) MULT |          | LTIPLE CONSTRUCTION (                                                  |           | (X3) DATE SURVEY |  |
|-----------|-----------------------------------|---------------------------------------------|----------------|----------|------------------------------------------------------------------------|-----------|------------------|--|
| AND PLAN  | OF CORRECTION                     | IDENTIFICATION NUMBER:                      | A. BU          | ILDING   | 00                                                                     | COMPLETED |                  |  |
|           |                                   | 15K064                                      | B. WI          | NG       |                                                                        | 06/05/2   | 2017             |  |
|           |                                   |                                             |                | STREET / | ADDRESS, CITY, STATE, ZIP CODE                                         |           |                  |  |
| NAME OF P | PROVIDER OR SUPPLIER              |                                             |                |          |                                                                        |           |                  |  |
|           | E HEALTH SERVIC                   | ESTIC                                       |                |          | 82ND ST STE 216<br>APOLIS, IN 46250                                    |           |                  |  |
| AT HOWI   | E HEALTH SERVIC                   | ES LLC                                      |                | INDIAN   | APOLIS, IN 40250                                                       |           |                  |  |
| (X4) ID   | SUMMARY S'                        | TATEMENT OF DEFICIENCIES                    |                | ID       | PROVIDER'S PLAN OF CORRECTION                                          |           | (X5)             |  |
| PREFIX    | (EACH DEFICIEN                    | CY MUST BE PRECEDED BY FULL                 |                | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ΓE        | COMPLETION       |  |
| TAG       | REGULATORY OR                     | LSC IDENTIFYING INFORMATION)                |                | TAG      | DEFICIENCY)                                                            |           | DATE             |  |
|           | Based on record                   | review and interview,                       | G 0            | 134      | Human Resources/designee w                                             |           | 08/25/2017       |  |
|           | the Administrato                  | or failed to ensure that                    |                |          | utilize a tracking system to ens                                       | sure      |                  |  |
|           | clinical staff annual performance |                                             |                |          | employee evaluations are                                               |           |                  |  |
|           |                                   | completed every 9 to 15                     |                |          | completed every 9 to 15 month as required by regulation. (To           |           |                  |  |
|           |                                   | of 7 employee records                       |                |          | completed by 8/25/17)                                                  | De        |                  |  |
|           |                                   |                                             |                |          | Human Resources will be                                                |           |                  |  |
|           | reviewed. (Emp                    | loyee G and H).                             |                |          | responsible to audit all current                                       |           |                  |  |
|           |                                   |                                             |                |          | employee files. Any employee                                           |           |                  |  |
|           | Findings include                  | :                                           |                |          | who has an evaluation that is p                                        | oast      |                  |  |
|           |                                   |                                             |                |          | due will have an evaluation                                            |           |                  |  |
|           | 1. The personne                   | l record for Employee G,                    |                |          | completed by their respective                                          |           |                  |  |
|           | -                                 | de, start date 3/21/11,                     |                |          | supervisor. (To be completed l                                         | by        |                  |  |
|           |                                   | e an annual performance                     |                |          | 8/25/17)                                                               |           |                  |  |
|           |                                   | e an annual performance                     |                |          | Human Resources will be                                                |           |                  |  |
|           | evaluation.                       |                                             |                |          | responsible to track outstandir evaluations to ensure they are         |           |                  |  |
|           |                                   |                                             |                |          | completed by 8/25/17.                                                  |           |                  |  |
|           | 2. The personne                   | l record for Employee H,                    |                |          | Human Resources will notify                                            |           |                  |  |
|           | a home health ai                  | de, start date 4/1/15,                      |                |          | supervisors monthly of employ                                          | ee        |                  |  |
|           | failed to evidenc                 | e an annual performance                     |                |          | evaluations due during that mo                                         |           |                  |  |
|           | evaluation.                       | 1                                           |                |          | and will monitor for compliance                                        | e to      |                  |  |
|           | o variation.                      |                                             |                |          | ensure evaluations are comple                                          |           |                  |  |
|           | 2 F1 A                            | 41                                          |                |          | timely. (To begin immediately)                                         |           |                  |  |
|           | 3. Employee A,                    |                                             |                |          | Administrator/Human Resourc                                            |           |                  |  |
|           | · ·                               | ndicated on 6/5/17 at                       |                |          | will be responsible for monitori                                       | •         |                  |  |
|           | 12:00 p.m., that                  | Employee G's annual                         |                |          | these corrective actions to ens                                        |           |                  |  |
|           | performance was                   | s completed by the                          |                |          | that this deficiency is corrected and will not recur.                  | 1         |                  |  |
|           | Administrator bu                  | it was not printed out                      |                |          | and will not recur.                                                    |           |                  |  |
|           |                                   | er prior to her going on                    |                |          |                                                                        |           |                  |  |
|           | •                                 | oyee A indicated she did                    |                |          |                                                                        |           |                  |  |
|           | •                                 | to the Administrators                       |                |          |                                                                        |           |                  |  |
|           |                                   |                                             |                |          |                                                                        |           |                  |  |
|           |                                   | A indicated Employee                        |                |          |                                                                        |           |                  |  |
|           | H's evaluation w                  | as not completed.                           |                |          |                                                                        |           |                  |  |
| 0.0440    | 404 44/                           |                                             |                |          |                                                                        |           |                  |  |
| G 0143    | 484.14(g)                         | OF DATIENT SERVICES                         |                |          |                                                                        |           |                  |  |
| Dida 00   |                                   | OF PATIENT SERVICES shing services maintain |                |          |                                                                        |           |                  |  |
| Bldg. 00  |                                   | hat their efforts are                       |                |          |                                                                        |           |                  |  |
|           |                                   | ively and support the                       |                |          |                                                                        |           |                  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 15 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                              | (X2) MULTIPLE CONSTRUCTION   |        |          | (X3) DATE SURVEY                                                    |        |            |
|------------------------------------------------------|----------------------------------------------|------------------------------|--------|----------|---------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                | IDENTIFICATION NUMBER:       | A. BU  | ILDING   | 00                                                                  | COMPL  | ETED       |
|                                                      |                                              | 15K064                       | B. WI  | NG       |                                                                     | 06/05/ | /2017      |
|                                                      |                                              |                              |        | STREET / | ADDRESS, CITY, STATE, ZIP CODE                                      |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                         | R                            |        |          | 82ND ST STE 216                                                     |        |            |
| ΔТ НОМ                                               | E HEALTH SERVIC                              | YES LLC                      |        |          | APOLIS, IN 46250                                                    |        |            |
|                                                      |                                              |                              |        |          |                                                                     |        |            |
| (X4) ID                                              |                                              | TATEMENT OF DEFICIENCIES     |        | ID       | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                               |                                              | ICY MUST BE PRECEDED BY FULL |        | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                  |                                              | LSC IDENTIFYING INFORMATION) |        | TAG      | DEFICIENCY)                                                         |        | DATE       |
|                                                      | <u> </u>                                     | d in the plan of care.       |        |          | Discotor of Numerica will in some                                   |        | 00/05/0015 |
|                                                      |                                              | review and interview,        | G 0143 |          | Director of Nursing will in-serv<br>nurses on coordinating care w   |        | 08/25/2017 |
|                                                      | the agency failed to ensure that their       |                              |        |          | all medical agencies involved                                       |        |            |
|                                                      | efforts were coo                             | rdinated effectively with    |        |          | patient. Training will include                                      | With   |            |
|                                                      | other health prov                            | viders serving their         |        |          | documenting name of agency                                          | ,      |            |
|                                                      | patients in 5 out                            | of 5 active records          |        |          | name/title of person spoke wit                                      |        |            |
|                                                      | -                                            | ents receiving outside       |        |          | payer, discipline(s), frequency                                     |        |            |
|                                                      | _                                            | nple of 10. (#5, 6, 7, 8     |        |          | duration and tasks to be provi                                      | ded.   |            |
|                                                      | and 10).                                     | 1910 01 10. (110, 0, 1, 0    |        |          | (To be done by 8/25/17)                                             |        |            |
|                                                      | aliu 10).                                    |                              |        |          | Director of Nursing will be responsible to ensure orientat          | ion    |            |
|                                                      |                                              |                              |        |          | of newly hired nurses includes                                      |        |            |
|                                                      | Findings include                             | <b>:</b>                     |        |          | training on coordinating care v                                     |        |            |
|                                                      |                                              |                              |        |          | all medical agencies involved                                       |        |            |
|                                                      | 1. The clinical r                            | record of patient #5, SOC    |        |          | patient. Training will include                                      |        |            |
|                                                      | 11/21/16, was re                             | viewed and included a        |        |          | documenting name of agency                                          |        |            |
|                                                      | plan of care for t                           | the certification period of  |        |          | name/title of person spoke wit                                      |        |            |
|                                                      | -                                            | 17. The plan of care         |        |          | payer, discipline(s), frequency                                     | ′,     |            |
|                                                      |                                              | tient was receiving          |        |          | duration and tasks to be provided. (To begin by 8/25/1              | 7)     |            |
|                                                      | _                                            | ational, and speech          |        |          | Director of Nursing/designee v                                      |        |            |
|                                                      |                                              | •                            |        |          | audit 100% of admissions,                                           |        |            |
|                                                      |                                              | fedicare agency and that     |        |          | resumptions and re-certification                                    | ons    |            |
|                                                      | _                                            | ed in a group home with      |        |          | to monitor for compliance of                                        |        |            |
|                                                      | _                                            | sion. The clinical record    |        |          | coordinating care with other                                        |        |            |
|                                                      | failed to evidence                           | e that the agency had        |        |          | medical agencies, if there are                                      |        |            |
|                                                      | coordinated serv                             | rices with the Medicare      |        |          | any. (To begin by 8/25/17)                                          |        |            |
|                                                      | agency and faile                             | d to evidence                |        |          | Director of Nursing will in-serv<br>nursing staff on requirement to |        |            |
|                                                      | coordination wit                             | h the group home of its      |        |          | notify MD of a patient's discha                                     |        |            |
|                                                      |                                              | elineation of duties with    |        |          | notify patient/caregiver of                                         | iige,  |            |
|                                                      | the home health                              |                              |        |          | discharge at least fifteen (15)                                     |        |            |
|                                                      | the nome hearth                              | agency.                      |        |          | days before discharge and                                           |        |            |
|                                                      | 2 The 11:11:1                                | and of notions IIC SOC       |        |          | notifying any other agency                                          |        |            |
|                                                      | 2. The clinical record of patient #6, SOC    |                              |        |          | involved in patient's care of                                       |        |            |
|                                                      | 1/30/17, was reviewed and included a         |                              |        |          | upcoming discharge of patient                                       |        |            |
|                                                      | plan of care for the certification period of |                              |        |          | from agency. Nurses to docun these conversations in patient         |        |            |
|                                                      | 3/31/17 to 5/29/                             | 17, with orders for skilled  |        |          | chart. (To be completed by                                          | . 5    |            |
|                                                      | nursing 3 times a                            | a week and home health       |        |          | 8/25/17)                                                            |        |            |
|                                                      | aide services 7 d                            |                              |        |          | Director of Nursing will be                                         |        |            |

| STATEMEN                               | T OF DEFICIENCIES               | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ONSTRUCTION                                                         | (X3) DATE SURVEY |            |  |
|----------------------------------------|---------------------------------|------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------|------------|--|
| AND PLAN                               | OF CORRECTION                   | IDENTIFICATION NUMBER:       | A. BU                          | JILDING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 00                                                                  | COMPL            | COMPLETED  |  |
|                                        |                                 | 15K064                       | B. W                           | ING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                     | 06/05/           | 2017       |  |
|                                        |                                 |                              |                                | STREET A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ADDRESS, CITY, STATE, ZIP CODE                                      |                  |            |  |
| NAME OF P                              | ROVIDER OR SUPPLIER             |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 82ND ST STE 216                                                     |                  |            |  |
| ΛТ НОМІ                                | E HEALTH SERVIC                 | ESTIC                        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | APOLIS, IN 46250                                                    |                  |            |  |
|                                        | L HEALTH SERVIC                 |                              |                                | INDIAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | AI OLIO, III 40230                                                  |                  |            |  |
| (X4) ID                                |                                 | TATEMENT OF DEFICIENCIES     |                                | ID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |  |
| PREFIX                                 | · ·                             | CY MUST BE PRECEDED BY FULL  |                                | PREFIX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE               | COMPLETION |  |
| TAG                                    | REGULATORY OR                   | LSC IDENTIFYING INFORMATION) | _                              | TAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DEFICIENCY)                                                         |                  | DATE       |  |
|                                        |                                 |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | responsible to ensure orientati                                     |                  |            |  |
|                                        | <ul> <li>A. During a</li> </ul> | home visit on 6/2/17 at      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | of newly hired nurses includes                                      |                  |            |  |
| 9:30 a.m., the patient was observed to |                                 |                              |                                | training on requirement to noting MD of a patient's discharge, noting the manufacture of |                                                                     |                  |            |  |
|                                        |                                 | ome. The clinical record     |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | patient/caregiver of discharge                                      |                  |            |  |
|                                        | • •                             | e that the agency had        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | least fifteen (15) days before                                      | ~                |            |  |
|                                        |                                 | ices with the group home     |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | discharge and notifying any ot                                      | her              |            |  |
|                                        |                                 |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | agency involved in patient's ca                                     | ire              |            |  |
|                                        | •                               | ns / delineation of duties   |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | of upcoming discharge of patie                                      |                  |            |  |
|                                        | with the home he                | ealth agency.                |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | from agency. Nurses to docum                                        |                  |            |  |
|                                        |                                 |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | these conversations in patient'                                     | s                |            |  |
|                                        |                                 | ecord for patient #7,        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | chart. (To begin by 8/25/17) Director of Nursing/designee v         | vill .           |            |  |
|                                        | SOC 12/31/16, in                | ncluded a plan of care for   |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | audit 100% of discharges to                                         | v III            |            |  |
|                                        | the certification               | period of 4/9/17 to          |                                | ensure compliance with notifying                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                     |                  |            |  |
|                                        | 6/7/17, with orde               | ers for home health aide     |                                | MD of upcoming discharge,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                     |                  |            |  |
|                                        | · ·                             | hours per day, 7 days a      |                                | notifying patient of discharge at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     |                  |            |  |
|                                        | week.                           | nours per any, r anys a      | least fifteen (15) days before |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | WCCK.                           |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | discharge and notifying other                                       |                  |            |  |
|                                        | 4 D .                           | C                            |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | agencies involved in patient's                                      |                  |            |  |
|                                        |                                 | of a recertification         |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | care of patient's upcoming discharge from agency. (To be            | agin             |            |  |
|                                        | -                               | ssessment dated 4/7/17,      |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8/25/17)                                                            | giii             |            |  |
|                                        | the "Professional               | l Services" narrative        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | The Director of Nursing will be                                     |                  |            |  |
|                                        | section indicated               | the patient was              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | responsible for monitoring thes                                     |                  |            |  |
|                                        | receiving home l                | nealth services with a       |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | corrective actions to ensure th                                     | at               |            |  |
|                                        | _                               | for wound treatments.        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | this deficiency is corrected and                                    | t                |            |  |
|                                        |                                 | ive assessment failed to     |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | will not recur.                                                     |                  |            |  |
|                                        | •                               | plete skin assessment,       |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        |                                 | site, of the patient's       |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | •                               | nical record failed to       |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        |                                 |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        |                                 | empted coordination with     |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | the Medicare age                | ency.                        |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        |                                 |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | B. A comm                       | unication log dated          |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | 5/2/17, indicated               | that the patient was         |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        |                                 | nealth services with a       |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | _                               | re agency for the            |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        |                                 |                              |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |
|                                        | i deadhent of Wol               | inds. The clinical record    | 1                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                  |            |  |

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR              |      |                               |                                                                    |        |                      |  |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------|-------------------------------|--------------------------------------------------------------------|--------|----------------------|--|
| AND PLAN          | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IDENTIFICATION NUMBER:                                |      | A. BUILDING <u>00</u> B. WING |                                                                    |        | COMPLETED 06/05/2017 |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15K064                                                | D. W |                               |                                                                    | 06/05/ | 2017                 |  |
| NAME OF I         | PROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ₹                                                     |      |                               | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                      |  |
| ат ном            | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SESTIC                                                |      |                               | 82ND ST STE 216<br>APOLIS, IN 46250                                |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                       | _    |                               | Al OLIO, III 40230                                                 |        | 710                  |  |
| (X4) ID<br>PREFIX |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL |      | ID<br>PREFIX                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)<br>COMPLETION   |  |
| TAG               | `                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | LSC IDENTIFYING INFORMATION)                          |      | TAG                           | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                     | ΓE     | DATE                 |  |
|                   | failed to evidence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ee that the agency had                                |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | vices with the correct                                |      |                               |                                                                    |        |                      |  |
|                   | Medicare agency.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |      |                               |                                                                    |        |                      |  |
|                   | and the second s |                                                       |      |                               |                                                                    |        |                      |  |
|                   | 4. The clinical r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | record for patient #8,                                |      |                               |                                                                    |        |                      |  |
|                   | SOC 8/3/16, inc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | luded a plan of care for                              |      |                               |                                                                    |        |                      |  |
|                   | the certification                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | period of 3/31/17 to                                  |      |                               |                                                                    |        |                      |  |
|                   | 5/29/17, with ore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ders for a home health                                |      |                               |                                                                    |        |                      |  |
|                   | aide up to 8 hour                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | rs a day, 7 days a week.                              |      |                               |                                                                    |        |                      |  |
|                   | The plan of care indicated the patient was                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                       |      |                               |                                                                    |        |                      |  |
|                   | receiving skilled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | nursing and home health                               |      |                               |                                                                    |        |                      |  |
|                   | aide services wit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | th a Medicare agency.                                 |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                       |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of the OASIS start of care                            |      |                               |                                                                    |        |                      |  |
|                   | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | assessment dated 8/3/16,                              |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | l Services" narrative                                 |      |                               |                                                                    |        |                      |  |
|                   | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | tient was receiving home                              |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | s times a week through a                              |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | y for management of                                   |      |                               |                                                                    |        |                      |  |
|                   | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | s to the patient's right arm                          |      |                               |                                                                    |        |                      |  |
|                   | and buttocks.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       |      |                               |                                                                    |        |                      |  |
|                   | D D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | of the OACIC                                          |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of the OASIS recertification assessment               |      |                               |                                                                    |        |                      |  |
|                   | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                       |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 3/30/17, the "Professional ive indicated the patient  |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tilled nursing and home                               |      |                               |                                                                    |        |                      |  |
|                   | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ces through a Medicare                                |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nical record failed to                                |      |                               |                                                                    |        |                      |  |
|                   | 1 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | e agency had coordinated                              |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e Medicare agency.                                    |      |                               |                                                                    |        |                      |  |
|                   | Services with the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ritodicate agency.                                    |      |                               |                                                                    |        |                      |  |
|                   | 5 The clinical r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | record for #10, SOC (start                            |      |                               |                                                                    |        |                      |  |
|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | , was reviewed and                                    |      |                               |                                                                    |        |                      |  |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. BUILDING 00  B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                        |                     | COMPLETED 06/05/2017                                                                                                                                                                                                       |     |                            |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------|
| NAME OF I                                             | PROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                      | 1                   | DDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                              | •   |                            |
| AT HOM                                                | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | INDIANAPOLIS, IN 46250 |                     | 82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                        |     |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T | ATE | (X5)<br>COMPLETION<br>DATE |
|                                                       | included a plan of certification of 3 orders for home 1 hour a day, 7 of personal care, bat of daily living, in reminders and literate plan.  A. The climit discharge OASIS dated 4/2/17. The to evidenced that had been notified patient's unsched patient had been the discharge and documentation in other home health the type of services, on 5/3 employee indicate the agency and in health agency will health agency will health Services patient. The employee C was certified to the certification of the certification | of care for the //7/17 to 5/5/17, with health aide services up to lays a week to assist with athing, dressing, activities heal prep, medication ght housekeeping per dical record evidenced a S discharge assessment he clinical record failed to the attending physician doin advance of the duled discharge, the informed in advance of defailed to provide he regards notifying the the agency and verifying ces being provided.  Wiew with the Employee that Director of Clinical 1/17 at 2:30 p.m., the ted the patient notified andicated another home has in the home. At Home decided to discharge the ployee indicated a 15 day rovided.  //17 at 2:30 p.m., so not unable to provide |                        |                     |                                                                                                                                                                                                                            |     |                            |
|                                                       | any further docu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | mentation upon request.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                        |                     |                                                                                                                                                                                                                            |     |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 19 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                                                                           | onstruction<br>00                                                                   | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                                                                              |                      |  |  |  |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--|--|--|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                    |                      |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                           | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                                                                                                              | (X5) COMPLETION DATE |  |  |  |
|                                                                                                            | Director of Clini<br>Employee C indi-<br>the care coordina<br>acknowledged the<br>with documentate<br>and coordination.  7. Employee A,<br>Administrator are<br>further information.  8. An undated popular "Coordination of<br>360, indicated "Ithis agency to en-<br>interchange, repo | ticated they are aware of ation component and a gency had a problem ation of all conversations as.  the Alternate and Employee B, had no on or documentation by ace on 6/5/17 at 3:50 p.m.  olicy titled at Client Services" C - t shall be the policy of asure effective orting and coordination mation provided by |                                                                                     |                                                                                                                                                                                                                                    |                      |  |  |  |
| G 0144<br>Bldg. 00                                                                                         | The clinical record conferences establishment care does Based on record the agency failed case conferences                                                                                                                                                                               | ting, and coordination of occur. review and interview, It to include minutes of of patient care in 8 out ds reviewed in a sample                                                                                                                                                                                     | G 0144                                                                              | Director of Nursing/designee in-service nurses on properly documenting the 60 Day Conference. Documentation include current disciplines, frequency, duration, tasks be provided, progress towards s goals – if not progressing the | to<br>ing<br>tated   |  |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 20 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | X2) MULTIPLE CONSTRUCTION      |       |          | (X3) DATE SURVEY                                                    |          |            |
|------------------------------------------------------|------------------------------|--------------------------------|-------|----------|---------------------------------------------------------------------|----------|------------|
| AND PLAN                                             | OF CORRECTION                | IDENTIFICATION NUMBER:         | A. BU | JILDING  | 00                                                                  | COMPL    | ETED       |
|                                                      |                              | 15K064                         | B. W  | ING      |                                                                     | 06/05/   | 2017       |
|                                                      |                              | <u> </u>                       |       | CTDEET / | ADDRESS, CITY, STATE, ZIP CODE                                      | <u> </u> |            |
| NAME OF P                                            | ROVIDER OR SUPPLIE           | R                              |       |          | 82ND ST STE 216                                                     |          |            |
| ΛΤ ⊔ <b>∩</b> Ν41                                    | E HEALTH SERVIO              | SESTIC                         |       |          |                                                                     |          |            |
| AT HOM                                               | E LIEAL IN SERVIC            | JES LLU                        |       | INDIAN   | IAPOLIS, IN 46250                                                   |          |            |
| (X4) ID                                              |                              | TATEMENT OF DEFICIENCIES       |       | ID       | PROVIDER'S PLAN OF CORRECTION                                       |          | (X5)       |
| PREFIX                                               | *                            | NCY MUST BE PRECEDED BY FULL   |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE      | COMPLETION |
| TAG                                                  | REGULATORY OF                | R LSC IDENTIFYING INFORMATION) | -     | TAG      | DEFICIENCY)                                                         |          | DATE       |
|                                                      |                              |                                |       |          | what changes need to be made                                        |          |            |
|                                                      | 1. A "60 day Ca              | ase Conference" sheets         |       |          | physical status, any concerns                                       | ,        |            |
|                                                      | dated 4/6/17, wa             | as reviewed. No sign in        |       |          | names of any other medical agencies that are providing              |          |            |
|                                                      | sheet provided.              |                                |       |          | service, etc. (To be completed                                      | d hv     |            |
|                                                      | sheet provided.              |                                |       |          | 8/25/17)                                                            | G Dy     |            |
|                                                      | A. D. in a Constitute #2     |                                |       |          | Director of Nursing will be                                         |          |            |
|                                                      | A. Review of patient #2 case |                                |       |          | responsible to ensure oriental                                      | tion     |            |
|                                                      |                              | "Update / Comments"            |       |          | of newly hired nurses include:                                      |          |            |
|                                                      |                              | w meds [medications] /         |       |          | training on properly documen                                        | ting     |            |
|                                                      | lost 6 lbs [pound            | -                              |       |          | the 60 Day Conference.                                              |          |            |
|                                                      | documentation v              | was included.                  |       |          | Documentation to include cur                                        |          |            |
|                                                      |                              |                                |       |          | disciplines, frequency, duration tasks being provided, progres      |          |            |
|                                                      | B. Review                    | of patient #3 case             |       |          | towards stated goals – if not                                       | 5        |            |
|                                                      |                              | "Update / Comments"            |       |          | progressing then what change                                        | es       |            |
|                                                      |                              | •                              |       |          | need to be made, physical sta                                       |          |            |
|                                                      |                              | changes, medset every 2        |       |          | any concerns, names of any of                                       |          |            |
|                                                      |                              | ants new doc [doctor] -        |       |          | medical agencies that are                                           |          |            |
|                                                      | change southern              |                                |       |          | providing service, etc. (To beg                                     | gin      |            |
|                                                      | documentation v              | was included.                  |       |          | by 8/25/17)                                                         |          |            |
|                                                      |                              |                                |       |          | Director of Nursing/designee                                        |          |            |
|                                                      | C. Review                    | of patient #5 case             |       |          | audit 100% of case conference                                       |          |            |
|                                                      |                              | "Update / Comments"            |       |          | notes, until 100% compliance achieved, to monitor for               | 13       |            |
|                                                      |                              | anges." No further             |       |          | compliance with proper                                              |          |            |
|                                                      | documentation v              | _                              |       |          | documentation of case                                               |          |            |
|                                                      | documentation \              | was included.                  |       |          | conference. Once 100%                                               |          |            |
|                                                      | D D .                        | - C 1: 1                       |       |          | compliance is achieved, Direct                                      |          |            |
|                                                      |                              | of patient #6 case             |       |          | of Nursing/designee will audit                                      |          |            |
|                                                      |                              | "Update / Comments"            |       |          | 25% of case conference note                                         |          |            |
|                                                      | indicated Group              | Home not checking on           |       |          | monthly to monitor for complia                                      | ance     |            |
|                                                      | her at night, kid            | ney issues." No further        |       |          | with properly documenting required information. (To begin           | in hv    |            |
|                                                      | documentation v              | was included.                  |       |          | 8/25/17)                                                            | пт Бу    |            |
|                                                      |                              |                                |       |          | Director of Nursing/designee                                        | will     |            |
|                                                      | E Review                     | of patient #7 case             |       |          | ensure there is a sign in shee                                      |          |            |
|                                                      |                              | "Update / Comments"            |       |          | all participating staff to sign.(S                                  |          |            |
|                                                      | ·                            | •                              |       |          | Attachment B) (To be comple                                         | ted      |            |
|                                                      |                              | anges, 101!, can't get out     |       |          | by 8/25/17)                                                         |          |            |
|                                                      |                              | further documentation          |       |          | Director of Nursing/designee                                        |          |            |
|                                                      | was included.                |                                |       |          | instruct nurses that aides are                                      | to       |            |

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                | ľ | ILDING              | nstruction<br><u>00</u>                                                                                                                                                                                                                                                                               | (X3) DATE (<br>COMPL<br>06/05/      | ETED                       |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |   | 6525 E              | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                  |                                     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                       |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                |                                     | (X5)<br>COMPLETION<br>DATE |
| TAG                      | F. Review of conference, the 'indicated "no chair."  G. Review of conference, the 'indicated "no chair."  G. Review of conference, the 'indicated "no chair."  2. A 60 day Cast dated 5/18/17, which included percords, 2 schedule Employee A, the Administrator, Endicated Services as Case sheet failed to extend the home health  A. Review of conference, the 'endicated the 'indicated to extend the 'indicated the 'i | of patient #8 case 'Update / Comments' anges - hoyer lift, shower  of patient #9 case 'Update / Comments' anges, cath change e / o'' No further was included.  e Conference sheets as reviewed. The sign in ersonnel from medical alers, quality assurance, e Alternate comployee B, the Director ces, and Employee C, the t Director of Clinical e Managers. The sign in widence the attendance of aides.  of patient #2 case 'Update / Comments' ng new.'' No further |   | TAG                 | be involved in case conference. Aides will be given notice of we case conferences are being do and their input will be asked. (be completed by 8/25/17) Director of Nursing will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur. | es.<br>hen<br>one<br>To<br>se<br>at | DATE                       |
|                          | conference, the '                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | of patient #3 case "Update / Comments" next week." No further was included.                                                                                                                                                                                                                                                                                                                                                                                             |   |                     |                                                                                                                                                                                                                                                                                                       |                                     |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 22 of 247

| -                        | OF CORRECTION                                         | IDENTIFICATION NUMBER:  15K064                                                                     | A. BU | A. BUILDING 00  B. WING |                                                                                                                        | COMPLETED 06/05/2017 |                            |
|--------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------|-------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------|
| NAME OF I                | PROVIDER OR SUPPLIER                                  |                                                                                                    |       | 1                       | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                       |                      |                            |
| AT HOM                   | E HEALTH SERVIC                                       | ES LLC                                                                                             |       |                         | APOLIS, IN 46250                                                                                                       |                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                        | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                  |       | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                   | (X5)<br>COMPLETION<br>DATE |
|                          | conference, the "indicated "deterion wheelchair, unab | of patient #4 case Update / Comments" orated since 4/25, ble to ambulate." No tation was included. |       |                         |                                                                                                                        |                      |                            |
|                          | conference, the "                                     | of patient #5 case Update / Comments" anges." No further vas included.                             |       |                         |                                                                                                                        |                      |                            |
|                          | conference, the "                                     | of patient #6 case Update / Comments" newal." No further vas included.                             |       |                         |                                                                                                                        |                      |                            |
|                          |                                                       |                                                                                                    |       |                         |                                                                                                                        |                      |                            |
|                          | conference, the "                                     | of patient #8 case Update / Comments" anges." No further vas included.                             |       |                         |                                                                                                                        |                      |                            |
|                          |                                                       | of patient #9 case<br>Update / Comments"                                                           |       |                         |                                                                                                                        |                      |                            |
|                          | evidence the effe                                     | conference failed to ective interchange in ing, interventions, and goals.                          |       |                         |                                                                                                                        |                      |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 23 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                         | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                                                              | 00                                                                                  | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                                                                                                                                                                                      |                      |  |  |  |
|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--|--|--|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                            |                      |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                          | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                                                                                                                              | (X5) COMPLETION DATE |  |  |  |
|                                                                                                            | comment in relate at 6/2/17 at 4:00  4. Employee A, Administrator and further information the exit conferents. An undated position of 360, indicated be held as necessinterchange, reposition between involved in the conferences evaluate the clients. | the Alternate d Employee B, had no on or documentation by ce on 6/5/17 at 3:50 p.m.  olicy titled C Client Services" C Care conferences will eary to establish orting, and coordinated een all disciplines lient's care Ongoing shall be conducted to nt's status and progress. ill be discussed and an |                                                                                     |                                                                                                                                                                                                                                                                                                                                            |                      |  |  |  |
| G 0145<br>Bldg. 00                                                                                         | A written summary sent to the attendi 60 days. Based on record the agency failed summaries were progress towards being met for 4 creviewed of paties                                                                                                    | OF PATIENT SERVICES or report for each patient is an physician at least every review and interview, to ensure 60 day reflective of the patients a goals being met and not out of 7 active records ents with recertifications 0. (#2, 3, 5 and 6)                                                        | G 0145                                                                              | Director of Nursing will in-serv<br>nurses on ensuring correct<br>information, to include correct<br>address and status of any<br>caregivers – disabled, refuse t<br>assist, etc, is on patient's Plan<br>Care. (To be done by 8/25/17)<br>Director of Nursing will in-serv<br>nurses on proper way to write<br>day summaries. Summaries a | o<br>of<br>ice<br>60 |  |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 24 of 247

| STATEME  | NT OF DEFICIENCIES                                                             | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | ULTIPLE CO | ONSTRUCTION                                                         | (X3) DATE | SURVEY     |
|----------|--------------------------------------------------------------------------------|------------------------------|--------|------------|---------------------------------------------------------------------|-----------|------------|
| AND PLAN | OF CORRECTION                                                                  | IDENTIFICATION NUMBER:       | A. BU  | JILDING    | 00                                                                  | COMPL     | ETED       |
|          |                                                                                | 15K064                       | B. W   | ING        |                                                                     | 06/05/    | 2017       |
|          |                                                                                |                              |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                      |           |            |
| NAME OF  | PROVIDER OR SUPPLIEF                                                           | 8                            |        |            | 82ND ST STE 216                                                     |           |            |
| AT HOM   | E HEALTH SERVIC                                                                | CES LLC                      |        |            | IAPOLIS, IN 46250                                                   |           |            |
| (X4) ID  | SUMMARY S                                                                      | TATEMENT OF DEFICIENCIES     |        | ID         | PROVIDER'S PLAN OF CORRECTION                                       |           | (X5)       |
| PREFIX   | (EACH DEFICIEN                                                                 | CY MUST BE PRECEDED BY FULL  |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION |
| TAG      | REGULATORY OR                                                                  | LSC IDENTIFYING INFORMATION) |        | TAG        | DEFICIENCY)                                                         |           | DATE       |
|          | Findings include                                                               | 2:                           |        |            | to be updated each recertifica                                      |           |            |
|          |                                                                                |                              |        |            | to reflect patient's actual statu<br>for the previous certification | IS        |            |
|          | 1. The clinical r                                                              | ecord for patient #2,        |        |            | period. This includes discussi                                      | na        |            |
|          | SOC (start of car                                                              | re) 03/06/12, was            |        |            | progress toward goals set for                                       | 19        |            |
|          | reviewed and included a plan of care for                                       |                              |        |            | patient. (To be completed by                                        |           |            |
|          |                                                                                | period of 2/8/17 to          |        |            | 8/25/17)                                                            |           |            |
|          |                                                                                | 7 to 6/7/17. The goals       |        |            | Director of Nursing will be                                         |           |            |
|          |                                                                                | ~                            |        |            | responsible to ensure orientat                                      |           |            |
|          | indicated "The client's safety will be enhanced through the home care services |                              |        |            | of newly hired nurses includes instruction on ensuring Plan or      |           |            |
|          |                                                                                |                              |        |            | Care reflects correct informati                                     |           |            |
|          | AEB [as evidenced by] no falls / injuries                                      |                              |        |            | and that 60 day summaries                                           |           |            |
|          | or ER visits within cert period. The                                           |                              |        |            | reflect patient's actual status t                                   | or        |            |
|          |                                                                                | mucous membranes will        |        |            | the previous certification period                                   | od.       |            |
|          | remain intact. T                                                               | he client's home             |        |            | (To begin by 8/25/17)                                               |           |            |
|          | environment wil                                                                | l be clean and safe,         |        |            | Director of Nursing/designee audit 100% of 60 day summan            |           |            |
|          | hygiene and pers                                                               | sonal care needs will be     |        |            | to monitor for compliance with                                      |           |            |
|          | met "                                                                          |                              |        |            | providing accurate summary of                                       |           |            |
|          |                                                                                |                              |        |            | patient's status, including                                         |           |            |
|          | A. A plan o                                                                    | f care for the certification |        |            | progress towards goals, the p                                       | ast       |            |
|          | _                                                                              | 17 to 04/08/17, included     |        |            | cert period. Once 100%                                              |           |            |
|          | 1 *                                                                            | ry that indicated "Client    |        |            | compliance is achieved, Direct of Nursing/designee will audit       |           |            |
|          | <u> </u>                                                                       | hensive assessment and       |        |            | 25% of 60 day summaries                                             |           |            |
|          | _                                                                              | f HHA [home health           |        |            | monthly to monitor for                                              |           |            |
|          |                                                                                | <del>-</del>                 |        |            | compliance. (To begin by                                            |           |            |
|          | 1 -                                                                            | lient to be recertified for  |        |            | 8/25/17).                                                           |           |            |
|          |                                                                                | of HHA services. Client      |        |            | Director of Nursing will be                                         |           |            |
|          |                                                                                | e who lives with her son,    |        |            | responsible for monitoring the corrective actions to ensure the     |           |            |
|          |                                                                                | de the home in one           |        |            | this deficiency is corrected an                                     |           |            |
|          |                                                                                | th basement, requires 24     |        |            | will not recur.                                                     | ~         |            |
|          | hour supervision                                                               | and assist with all          |        |            |                                                                     |           |            |
|          | ADL's [activities                                                              | s of daily living] and       |        |            |                                                                     |           |            |
|          | IADL's [Instrum                                                                | ental activities of daily    |        |            |                                                                     |           |            |
|          | living]. Patient                                                               | is non ambulatory and        |        |            |                                                                     |           |            |
|          | non verbal d/t [due to] severe dementia.                                       |                              |        |            |                                                                     |           |            |
|          | _                                                                              | of End Stage Alzheimer's     |        |            |                                                                     |           |            |
|          |                                                                                | nypertension], urinary and   |        |            |                                                                     |           |            |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| -                        | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A. BUILDING 00  B. WING |                                                                                                                       | COMPLETED 06/05/2017 |                            |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------|
| NAME OF I                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         | T ADDRESS, CITY, STATE, ZIP CODE                                                                                      | •                    |                            |
| AT HOM                   | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | E 82ND ST STE 216<br>NAPOLIS, IN 46250                                                                                |                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE                  | (X5)<br>COMPLETION<br>DATE |
| TAG                      | bowel incontiner Client is non-am total transfers, ba prep (mechanical feeding, medicat incontinence care Client lives with employed full tir is need of assista Client is incontin bladder increasin breakdown, patie briefs. Caregive just had lunch. O when nurse arriv client had no cha medications, no hospitalizations. clear, heart irregi [within normal li abdomen soft / n Pedal pulses palp patient unable to pounds. Family care / services pr Client's MD noti care with no chai  B. A plan of period of 4/9/17 day summary tha for comprehensiv recertification of | ice, and impaired gait. bulatory and requires athing, dressing, meal I soft diet), set up and ion reminders, e and light housekeeping. her son who is ne outside the home and nce to care for patient. tent of bowel and light housekeeping. her son who is ne outside the home and nce to care for patient. The present of skin ent does wear adult for present, stated patient client asleep on sofa led, caregiver stated light no new visits to ER / Lung sounds were lalar, bowel sounds WNL | TAG                     | DEFICIENCY)                                                                                                           |                      | DATE                       |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 26 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|           |                      | IULTIPLE CO<br>UILDING                         | NSTRUCTION<br>00 | COMPL    |                                                                                      |        |            |
|-----------|----------------------|------------------------------------------------|------------------|----------|--------------------------------------------------------------------------------------|--------|------------|
|           |                      | 15K064                                         | B. W             |          | 00                                                                                   | 06/05/ |            |
|           |                      | - 1                                            |                  | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                       | 1      |            |
| NAME OF F | PROVIDER OR SUPPLIER |                                                |                  |          | 82ND ST STE 216                                                                      |        |            |
| AT HOM    | E HEALTH SERVIC      | ES LLC                                         |                  |          | APOLIS, IN 46250                                                                     |        |            |
| (X4) ID   |                      | TATEMENT OF DEFICIENCIES                       |                  | ID       | PROVIDER'S PLAN OF CORRECTION                                                        |        | (X5)       |
| PREFIX    | ,                    | CY MUST BE PRECEDED BY FULL                    |                  | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE    | COMPLETION |
| TAG       |                      | LSC IDENTIFYING INFORMATION)                   |                  | TAG      | DEFICIENCT)                                                                          |        | DATE       |
|           | *                    | of HHA services. Client who believes with her  |                  |          |                                                                                      |        |            |
|           |                      | outside the home in one                        |                  |          |                                                                                      |        |            |
|           | · ·                  | th basement, requires 24                       |                  |          |                                                                                      |        |            |
|           |                      | and assist with all                            |                  |          |                                                                                      |        |            |
|           | •                    | s of daily living] and                         |                  |          |                                                                                      |        |            |
|           | _                    |                                                |                  |          |                                                                                      |        |            |
|           | -                    | ental activities of daily s non ambulatory and |                  |          |                                                                                      |        |            |
|           |                      | ue to] severe dementia.                        |                  |          |                                                                                      |        |            |
|           | _                    | of End Stage Alzheimer's                       |                  |          |                                                                                      |        |            |
|           |                      | hypertension], urinary and                     |                  |          |                                                                                      |        |            |
|           |                      | nce, and impaired gait.                        |                  |          |                                                                                      |        |            |
|           |                      | bulatory and requires                          |                  |          |                                                                                      |        |            |
|           |                      | athing, dressing, meal                         |                  |          |                                                                                      |        |            |
|           |                      | l soft diet), set up and                       |                  |          |                                                                                      |        |            |
|           | feeding, medicat     | -                                              |                  |          |                                                                                      |        |            |
|           | _                    | e and light housekeeping.                      |                  |          |                                                                                      |        |            |
|           | Client lives with    |                                                |                  |          |                                                                                      |        |            |
|           |                      | ne outside the home and                        |                  |          |                                                                                      |        |            |
|           |                      | ance to care for patient.                      |                  |          |                                                                                      |        |            |
|           |                      | nent of bowel and                              |                  |          |                                                                                      |        |            |
|           |                      | ng the risk of skin                            |                  |          |                                                                                      |        |            |
|           |                      | ent does wear adult                            |                  |          |                                                                                      |        |            |
|           |                      | er present, stated patient                     |                  |          |                                                                                      |        |            |
|           | _                    | Client asleep on sofa                          |                  |          |                                                                                      |        |            |
|           |                      | red, caregiver stated                          |                  |          |                                                                                      |        |            |
|           |                      | inge in condition, no new                      |                  |          |                                                                                      |        |            |
|           | medications, no      | •                                              |                  |          |                                                                                      |        |            |
|           |                      | Lung sounds were                               |                  |          |                                                                                      |        |            |
|           | -                    | ular, bowel sounds WNL                         |                  |          |                                                                                      |        |            |
|           | [within normal li    |                                                |                  |          |                                                                                      |        |            |
|           | I =                  | on-tender to palpitation.                      |                  |          |                                                                                      |        |            |
|           |                      | pable, no edema noted                          |                  |          |                                                                                      |        |            |
|           |                      | stand for height, Wt 76                        |                  |          |                                                                                      |        |            |
|           | 1                    |                                                |                  |          |                                                                                      |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 27 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                          | ľ í                          | ULTIPLE CO.<br>UILDING | NSTRUCTION 00 | COMPL                                                                  |        |            |
|-----------------------------------------------|------------------------------------------|------------------------------|------------------------|---------------|------------------------------------------------------------------------|--------|------------|
| THIND I LIMIT                                 | or conduction                            | 15K064                       | B. W                   |               | 00                                                                     | 06/05/ |            |
|                                               |                                          | 1011001                      |                        | CTDEET A      | DDDECC CITY CTATE ZID CODE                                             | 00/00/ | 2011       |
| NAME OF F                                     | PROVIDER OR SUPPLIEF                     | 2                            |                        | 1             | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                       |        |            |
| AT HOMI                                       | E HEALTH SERVIC                          | CES LLC                      |                        | 1             | APOLIS, IN 46250                                                       |        |            |
| (X4) ID                                       | SUMMARY S                                | TATEMENT OF DEFICIENCIES     |                        | ID            | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX                                        | ,                                        | CY MUST BE PRECEDED BY FULL  |                        | PREFIX        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE    | COMPLETION |
| TAG                                           |                                          | LSC IDENTIFYING INFORMATION) |                        | TAG           | DEFICIENCY)                                                            |        | DATE       |
|                                               | 1                                        | reports satisfaction with    |                        |               |                                                                        |        |            |
|                                               | -                                        | rovided by agency.           |                        |               |                                                                        |        |            |
| Client's MD notified of recertification of    |                                          |                              |                        |               |                                                                        |        |            |
|                                               | care with no changes to care plan."      |                              |                        |               |                                                                        |        |            |
|                                               | C. A home visit on 6/1/17 at 9:15        |                              |                        |               |                                                                        |        |            |
|                                               | a.m., was conducted at the patient's     |                              |                        |               |                                                                        |        |            |
|                                               | daughters home                           | where the patient had        |                        |               |                                                                        |        |            |
|                                               | been residing. T                         | The new address of           |                        |               |                                                                        |        |            |
|                                               | residence was no                         | ot listed on the plan of     |                        |               |                                                                        |        |            |
|                                               | care. The plan of care included a former |                              |                        |               |                                                                        |        |            |
|                                               | address where services were initially    |                              |                        |               |                                                                        |        |            |
|                                               |                                          | ng this time, the home       |                        |               |                                                                        |        |            |
|                                               | _                                        | ated the patient use to      |                        |               |                                                                        |        |            |
|                                               |                                          | but moved in with the        |                        |               |                                                                        |        |            |
|                                               | daughter and had                         | d been residing with the     |                        |               |                                                                        |        |            |
|                                               | _                                        | ong time and could not       |                        |               |                                                                        |        |            |
|                                               | _                                        | the patient had moved.       |                        |               |                                                                        |        |            |
|                                               |                                          | a aide also indicated that   |                        |               |                                                                        |        |            |
|                                               | the daughter was                         |                              |                        |               |                                                                        |        |            |
|                                               |                                          |                              |                        |               |                                                                        |        |            |
|                                               | The 60 day sum                           | maries was repetitive        |                        |               |                                                                        |        |            |
|                                               | from the admiss                          | ion summary and failed       |                        |               |                                                                        |        |            |
|                                               | to be updated an                         | d be reflective of the       |                        |               |                                                                        |        |            |
|                                               | patient status du                        | ring the 60 day period       |                        |               |                                                                        |        |            |
|                                               | and progress tow                         | vard goals at the time of    |                        |               |                                                                        |        |            |
|                                               | the recertificatio                       | n.                           |                        |               |                                                                        |        |            |
|                                               | 2 The clinical r                         | record for patient #3,       |                        |               |                                                                        |        |            |
|                                               |                                          | was reviewed and             |                        |               |                                                                        |        |            |
|                                               | included a plan                          |                              |                        |               |                                                                        |        |            |
|                                               | _                                        |                              |                        |               |                                                                        |        |            |
|                                               | _                                        | od of 3/26/17 to 5/26/17     |                        |               |                                                                        |        |            |
|                                               |                                          | /27/17. The goals            |                        |               |                                                                        |        |            |
|                                               | indicated "Clien                         | t will take medications as   |                        |               |                                                                        |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 28 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:                                        |                                                                                 |                                                | ULTIPLE CO<br>UILDING | 00       | (X3) DATE<br>COMPL                                                                    |        |            |
|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------|-----------------------|----------|---------------------------------------------------------------------------------------|--------|------------|
| 11112 12111                                                                          | or country.                                                                     | 15K064                                         | B. W                  |          | 00                                                                                    | 06/05/ |            |
|                                                                                      |                                                                                 |                                                |                       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                        |        | -          |
| NAME OF I                                                                            | PROVIDER OR SUPPLIER                                                            | R                                              |                       | 1        | 82ND ST STE 216                                                                       |        |            |
| AT HOM                                                                               | E HEALTH SERVIC                                                                 | ES LLC                                         |                       | INDIAN   | APOLIS, IN 46250                                                                      |        |            |
| (X4) ID                                                                              | SUMMARY S                                                                       | TATEMENT OF DEFICIENCIES                       |                       | ID       | PROVIDER'S PLAN OF CORRECTION                                                         |        | (X5)       |
| PREFIX                                                                               | •                                                                               | CY MUST BE PRECEDED BY FULL                    |                       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                                                  |                                                                                 | LSC IDENTIFYING INFORMATION)                   |                       | TAG      | DEFICIENCY)                                                                           |        | DATE       |
|                                                                                      |                                                                                 | B visual inspection of caregiver verbalize     |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | •                                              |                       |          |                                                                                       |        |            |
| compliance, pill count is appropriate this cert period, The patient's safety will be |                                                                                 |                                                |                       |          |                                                                                       |        |            |
|                                                                                      | -                                                                               | hout the home care                             |                       |          |                                                                                       |        |            |
|                                                                                      | _                                                                               |                                                |                       |          |                                                                                       |        |            |
|                                                                                      | services AEB no falls / injuries or ER visits within cert period. The patient's |                                                |                       |          |                                                                                       |        |            |
| skin and mucous membranes will remain                                                |                                                                                 |                                                |                       |          |                                                                                       |        |            |
| intact. The patient's home environment                                               |                                                                                 |                                                |                       |          |                                                                                       |        |            |
| will be clean and safe, hygiene and                                                  |                                                                                 |                                                |                       |          |                                                                                       |        |            |
|                                                                                      | personal care needs will be met.                                                |                                                |                       |          |                                                                                       |        |            |
|                                                                                      | 1                                                                               |                                                |                       |          |                                                                                       |        |            |
|                                                                                      | A. The plan                                                                     | of care for the                                |                       |          |                                                                                       |        |            |
|                                                                                      | certification peri                                                              | od of 3/26/17 to 5/26/17,                      |                       |          |                                                                                       |        |            |
|                                                                                      | included a 60 da                                                                | y summary that indicated                       |                       |          |                                                                                       |        |            |
|                                                                                      | "Client seen by l                                                               | RN for comprehensive                           |                       |          |                                                                                       |        |            |
|                                                                                      | assessment for re                                                               | ecertification of services.                    |                       |          |                                                                                       |        |            |
|                                                                                      | Client to be rece                                                               | rtified for another                            |                       |          |                                                                                       |        |            |
|                                                                                      | -                                                                               | rvices. Client is an                           |                       |          |                                                                                       |        |            |
|                                                                                      | 1                                                                               | male who lives alone in                        |                       |          |                                                                                       |        |            |
|                                                                                      | an apartment wit                                                                | •                                              |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | s, diabetes, hypertension,                     |                       |          |                                                                                       |        |            |
|                                                                                      | 1                                                                               | er disorder, morbid                            |                       |          |                                                                                       |        |            |
|                                                                                      | 1                                                                               | s requiring SN every two                       |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | ation setup, teaching                          |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | to monitor compliance                          |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | and efficacy and HHA                           |                       |          |                                                                                       |        |            |
|                                                                                      | _                                                                               | e, meal prep / set up, and                     |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | ng. Client is a high fall                      |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | nit and ambulates with                         |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | es, has poor endurance,<br>furine and requires |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | each incontinent episode.                      |                       |          |                                                                                       |        |            |
|                                                                                      |                                                                                 | ER / hospitalizations this                     |                       |          |                                                                                       |        |            |
|                                                                                      | Demica visits to                                                                | ER / HOSPITALIZATIONS THIS                     |                       |          |                                                                                       |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 29 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00                                                                                                 | (X3) DATE SURVEY  COMPLETED  06/05/2017 |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                           |                                                                                                                                                                                                                           | 6525 E                                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>NAPOLIS, IN 46250                                          |                                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                    | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                         | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | BE COMPLETION                           |
|                          | oriented but state<br>and HOH [hard of<br>verbalized satisf<br>and services to be                                                                                 | od. Client is alert and ed he / she is forgetful of hearing] Client faction with plan of care provided. Physician tification and POC [plan                                                                                |                                            |                                                                                                                 |                                         |
| (                        | certification peri<br>included a 60 da<br>"Client seen by l<br>assessment for re<br>Client to be rece<br>episode HHA se<br>elderly male / fe<br>an apartment with | <del>-</del>                                                                                                                                                                                                              |                                            |                                                                                                                 |                                         |
|                          | kidney and urete<br>obesity. Client i<br>weeks for medic<br>medication and t<br>with medication<br>for personal care<br>housekeeping. C                           | s, diabetes, hypertension, or disorder, morbid s requiring SN every two ation setup, teaching to monitor compliance and efficacy and HHA e, meal prep / set up, light Client is a high fall risk, d ambulates with walker |                                            |                                                                                                                 |                                         |
|                          | incontinent of ur<br>assistance with e<br>Denied visits to<br>certification peri<br>oriented but state<br>and HOH [hard                                           | poor endurance, is rine and requires each incontinent episode. ER / hospitalizations this od. Client is alert and ed he / she is forgetful of hearing] Client faction with plan of care                                   |                                            |                                                                                                                 |                                         |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 30 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                         | A. BUILDING 00 C                                                                                                                                                                                |                     |                                                                                                                   | survey<br>eted<br>2017 |                            |
|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                 |                                                                                                                                                                                                 | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>8 82ND ST STE 216<br>NAPOLIS, IN 46250                                          | •                      |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                          | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                     | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            |                                                                                                                                                                                         | e provided. Physician tification and POC.                                                                                                                                                       |                     |                                                                                                                   |                        |                            |
|                                                                                                            | from the admissi<br>to be updated an<br>patient status du                                                                                                                               | maries was repetitive ion summary and failed d be reflective of the ring the 60 day period ward goals at the time of n.                                                                         |                     |                                                                                                                   |                        |                            |
|                                                                                                            | SOC 11/21/16, vincluded a plan of certification period The goals indicated will be enhanced care services AE ER visits with constitution and mucous intact. The patients                | od of 5/20/17 to 7/18/17.  ted "The patient's safety I throughout the home B no falls / injuries or ert period. The patients s membranes will remain ent's home environment I safe, hygiene and |                     |                                                                                                                   |                        |                            |
|                                                                                                            | certification peri<br>1/19/17, include<br>that indicated "C<br>comprehensive a<br>recertification. (<br>admitted for HH<br>Has decreased d<br>Requires assist w<br>reminders and period | 64 year old male / female<br>A with dx of dementia.<br>exterity and mentation.                                                                                                                  |                     |                                                                                                                   |                        |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 31 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                         | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                          | ONSTRUCTION  00                                                                                          | (X3) DATE<br>COMPI<br><b>06/05</b> | LETED                      |  |  |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------|--|--|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                          |                                    |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR                                                                                                                                                                                                                                                                             | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPRODEFICIENCY) | O BE                               | (X5)<br>COMPLETION<br>DATE |  |  |
|                          | to assist with per<br>housekeeping. If<br>home with one s<br>supervisor Cli<br>satisfaction with<br>to be provided.<br>recertification ar                                                                                                                                                                   | Patient lives in a group taff member to ent verbalized plan of care and services Physician notified of                                                                                                                                                                                     |                                                                                     |                                                                                                          |                                    |                            |  |  |
|                          | certification peri<br>included an 60 d<br>indicated "Client<br>comprehensive a<br>recertification. 6<br>admitted for HH<br>Has decreased do<br>Requires assist we<br>reminders and powith minimal ex<br>incontinent of bl<br>to assist with per<br>housekeeping. If<br>home with one s<br>supervisor Client | ay summary that t seen by RN for assessment 64 year old male / female A with dx of dementia. exterity and mentation. with medication ersonal care. Tires easily ertion. Is a fall risk and adder and bowel. Aide rsonal care, light Patient lives in a group taff member to ent verbalized |                                                                                     |                                                                                                          |                                    |                            |  |  |
|                          | to be provided. recertification ar  C. Review of patient was hosp possible seizure                                                                                                                                                                                                                          | plan of care and services Physician notified of ad POC.  of the clinical record, the italized in April for activity AEB resumption nt dated 04/21/17.                                                                                                                                      |                                                                                     |                                                                                                          |                                    |                            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 32 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:                                 |                     | l ,                                                 | ULTIPLE CO.<br>JILDING | NSTRUCTION 00 | (X3) DATE<br>COMPL                                                  |        |            |
|-------------------------------------------------------------------------------|---------------------|-----------------------------------------------------|------------------------|---------------|---------------------------------------------------------------------|--------|------------|
| 11112 12111                                                                   | or confidence.      | 15K064                                              | B. WI                  |               | 00                                                                  | 06/05/ |            |
|                                                                               |                     |                                                     |                        | STREET A      | DDRESS, CITY, STATE, ZIP CODE                                       |        |            |
| NAME OF F                                                                     | ROVIDER OR SUPPLIER |                                                     |                        |               | 82ND ST STE 216                                                     |        |            |
| AT HOMI                                                                       | E HEALTH SERVIC     | ES LLC                                              |                        | INDIAN        | APOLIS, IN 46250                                                    |        |            |
| (X4) ID                                                                       | SUMMARY S           | TATEMENT OF DEFICIENCIES                            |                        | ID            | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                                                        | ·                   | CY MUST BE PRECEDED BY FULL                         |                        | PREFIX        | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE.   | COMPLETION |
| TAG                                                                           |                     | LSC IDENTIFYING INFORMATION)                        |                        | TAG           | DEFICIENCY)                                                         |        | DATE       |
|                                                                               | •                   | of care for the                                     |                        |               |                                                                     |        |            |
|                                                                               | •                   | od of 5/20/17 to 7/18/17,                           |                        |               |                                                                     |        |            |
| included a 60 day summary that indicated "Client seen by RN for comprehensive |                     |                                                     |                        |               |                                                                     |        |            |
|                                                                               | _                   | tification. 64 year old                             |                        |               |                                                                     |        |            |
|                                                                               |                     | mitted for HHA with dx                              |                        |               |                                                                     |        |            |
|                                                                               |                     |                                                     |                        |               |                                                                     |        |            |
| of dementia. Has decreased dexterity and mentation. Requires assist with      |                     |                                                     |                        |               |                                                                     |        |            |
|                                                                               |                     | nders and personal care.                            |                        |               |                                                                     |        |            |
| Tires easily with minimal exertion. Is a                                      |                     |                                                     |                        |               |                                                                     |        |            |
| fall risk and incontinent of bladder and                                      |                     |                                                     |                        |               |                                                                     |        |            |
| bowel. Aide to assist with personal care,                                     |                     |                                                     |                        |               |                                                                     |        |            |
|                                                                               |                     | ng. Patient lives in a                              |                        |               |                                                                     |        |            |
|                                                                               |                     | one staff member to                                 |                        |               |                                                                     |        |            |
|                                                                               |                     | 24 hrs [hours] day                                  |                        |               |                                                                     |        |            |
|                                                                               |                     | satisfaction with plan of                           |                        |               |                                                                     |        |            |
|                                                                               | care and services   | s to be provided.                                   |                        |               |                                                                     |        |            |
|                                                                               | Physician notifie   | ed of recertification and                           |                        |               |                                                                     |        |            |
|                                                                               | POC."               |                                                     |                        |               |                                                                     |        |            |
|                                                                               | E Animan            | in id the Discourse C                               |                        |               |                                                                     |        |            |
|                                                                               |                     | view with the Director of                           |                        |               |                                                                     |        |            |
|                                                                               |                     | s on 6/5/17 at 12:45 p.m.,                          |                        |               |                                                                     |        |            |
|                                                                               |                     | e patient did not start<br>e services until 1/26/17 |                        |               |                                                                     |        |            |
|                                                                               |                     | y waiting on Medicaid                               |                        |               |                                                                     |        |            |
|                                                                               | Prior Authorizat    | -                                                   |                        |               |                                                                     |        |            |
|                                                                               | Thoi rumonzai       | ιοπ αρριοναι.                                       |                        |               |                                                                     |        |            |
|                                                                               | The 60 day sumi     | maries was repetitive                               |                        |               |                                                                     |        |            |
|                                                                               | _                   | ion summary and failed                              |                        |               |                                                                     |        |            |
|                                                                               |                     | d be reflective of the                              |                        |               |                                                                     |        |            |
|                                                                               | •                   | ring the 60 day period                              |                        |               |                                                                     |        |            |
|                                                                               | -                   | vard goals at the time of                           |                        |               |                                                                     |        |            |
|                                                                               | the recertificatio  | _                                                   |                        |               |                                                                     |        |            |
|                                                                               |                     |                                                     |                        |               |                                                                     |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 33 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                  |    |                            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|------------------------------------------------------------------------------------------------------------------------|----|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6525 E              | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                   |    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            | 1/30/17, was revered plan of care for to 3/31/17 to 5/29/15 nursing to provide times a week, understoom times a week, understoom to be long term of the client's safet throughout the homofalls / injuriest period. The client's home entered and safe, hygient will be met."  A. The plant certification perioneluded an admit indicated "53 years admitted for SN HHA [home heard at [diagnosis] of decreased dextered with bowel regiment unable to dependent for perhousekeeping | ecord of patient #6, SOC iewed and included a the certification period of 17, with orders for skilled de a bowel program 3 ostomy irrigation, and gement. The goals killed nurse] is expected due to disease process. Ith aide] care is expected due to disease process. Ith aide] care is expected due to disease process. Ith aide one care services AEB is or ER visits within cert int's skin and mucous remain intact. The evironment will be clean e and personal care needs and personal care needs are of care for the od of 1/30/17 to 3/30/17, ission summary that are old male / female [skilled nursing] and Ith aide] r/t [related to] of Spina Bifada. Has inty and requires assist the and ostomy care, is perform care for self, ersonal care, light in the control of the care for |  |                     |                                                                                                                        |    |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 34 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | A. BUILDING 00  B. WING |                                                                                      |       | LETED 5/2017         |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------|-------|----------------------|
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 6525                    | EET ADDRESS, CITY, STATE, ZIP COE<br>5 E 82ND ST STE 216<br>NANAPOLIS, IN 46250      | Έ     |                      |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY ST<br>(EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP | LD BE | (X5) COMPLETION DATE |
|                          | included an 60 daindicated "Client comprehensive a recertification. 5 admitted for SN HHA [home heard dx [diagnosis] of decreased dexter with bowel regin patient unable to dependent for pe a slide board for with minimal excincontinent of bourine. Aide to as light housekeepin. The 60 day summar from the admissing to be updated and patient status durand progress tow the recertification.  5. Employee B, Services and Employee B, Services and Employee A, Administrator and findings at 6/2/1. | seen by RN for ssessment  3 year old male / female [skilled nursing] and th aide] r/t [related to]  Spina Bifada. Has ity and requires assist ne and ostomy care, perform care for self, rsonal care. Patient uses transfers. Tires easily ertion. Is a high fall risk, wel and urostomy for sist with personal care, ng "  maries was repetitive on summary and failed d be reflective of the ring the 60 day period ard goals at the time of n.  the Director of Clinical ployee C, the Interim or of Clinical Services, in relation to the above 7 at 4:00 p.m. |                         |                                                                                      |       |                      |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 35 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                    | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                              | (X2) MULTIPLE C A. BUILDING B. WING | onstruction<br><u>00</u>                                                                             | CON    | TE SURVEY<br>MPLETED<br>05/2017 |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------|--------|---------------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                       | 6525 E                              | ADDRESS, CITY, STATE, ZIP CO<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                               | DE     |                                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>DATE      |
|                          | the exit conferen                                                                                                                                                                                                                                                                                                                                                                                      | ce on 6/5/17 at 3:50 p.m.                                                                                                                                                                                                                                                                                             |                                     |                                                                                                      |        |                                 |
| G 0147                   | 484.14(i)<br>INSTITUTIONAL F                                                                                                                                                                                                                                                                                                                                                                           | DI ANNING                                                                                                                                                                                                                                                                                                             |                                     |                                                                                                      |        |                                 |
| Bldg. 00                 | The HHA, under the governing body, per and a budget that                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                       |                                     |                                                                                                      |        |                                 |
|                          | annual operating the anticipated income items that would, the accounting principand expense items required that there connection with an                                                                                                                                                                                                                                                               | ny budget, an item by item<br>e components of each type                                                                                                                                                                                                                                                               |                                     |                                                                                                      |        |                                 |
|                          | at least a 3-year p<br>operating budget y<br>and identifies in do<br>sources of financin<br>of, each anticipate<br>than \$600,000 for<br>generally accepted<br>considered capital<br>single capital expe<br>\$600,000, the cos<br>designs, plans, wo<br>specifications, and<br>to the acquisition,<br>modernization, ex<br>land, plant, buildin<br>included. Expending<br>related to capital expending | pital expenditure plan for eriod, including the year. The plan includes etail the anticipated and for, and the objectives and expenditure of more items that would under diaccounting principles, be items. In determining if a enditure exceeds to f studies, surveys, orking drawings, diother activities essential |                                     |                                                                                                      |        |                                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 36 of 247

|                          | T OF DEFICIENCIES  OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                | ONSTRUCTION  00                                                                                                              | (X3) DATE SURVEY COMPLETED 06/05/2017 |  |  |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|--|
|                          | ROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                                              |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                | (X5) COMPLETION DATE                  |  |  |
|                          | and costs involved structures on land Transactions that are components of care objective, are without regard to be related to capital of fees, permit and lift commissions, are and appraisal fees carrying charges of costs incurred for (ii) If the anticipatin any part, the antitle V (Maternal a Crippled Children' (Medicare) or title Social Security Active following:  (A) Whether the expenditure is required standards, criterial accordance with the Act or the Mental Community Mental Community Mental Construction Active (B) Whether aproposal has been designated plannin accordance with sure under the Mental Community Mental Construction Active (C) Whether approposal has been designated plannin accordance with sure under the Mental Community Mental Construction Active (B) Whether approposal has been designated plannin accordance with sure under the mental community Mental Construction Active (B) Whether approposal has appropriated to that appropriate for the mental constructions.  (C) Whether the agency has appropriated to that appropriate for the mental constructions. | ated source of financing is, aticipated payment from and Child Health and as Services) or title XVIII XIX (Medicaid) of the ct, the plan specifies the the proposed capital uired to conform, or is ed to conform, to current and the Public Health Service Retardation Facilities and all Health Centers of 1963. The acapital expenditure and an appropriate to the angle agency for approval in the expenditure of the Act (42 and implementing the designated planning agency. | C 0147                                                                                    | Administrator will keep printed                                                                                              | 09/25/2017                            |  |  |
|                          | ensure that an ov                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ew, the agency failed to verall plan and a budget mual operating budget                                                                                                                                                                                                                                                                                                                                                                                                            | G 0147                                                                                    | Administrator will keep printed copy of Annual Operating Bud and Capital Expenditure Budg available in office. Will instruct | lget<br>et                            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 37 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUILDING                                                                         | 00                                                                                                                                            | COMPLETED            |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--|
|                                               | 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WING                                                                             |                                                                                                                                               | 06/05/2017           |  |
|                                               | PROVIDER OR SUPPLIER E HEALTH SERVICES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                               |                      |  |
| (X4) ID<br>PREFIX<br>TAG                      | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                 | (X5) COMPLETION DATE |  |
|                                               | and capital expenditure was provided upon request for 1 of 1 home health agency.                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     | Alternate Administrator and Director of Nursing on location printed copy of budget. (To be done by 8/25/17) Administrator will be responsible |                      |  |
|                                               | Findings include:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     | for monitoring these corrective                                                                                                               |                      |  |
|                                               | <ol> <li>On 06/05/17 at , the Alternate         Administrator was unable to provide an overall plan and a budget that included annual operating budget and capital expenditure upon request.     </li> <li>Employee A, the Alternate         Administrator, indicated on 06/05/17 at 2:00 p.m., that the Administrator was on vacation and was told that the information was in the Administrators computer. The Alternate Administrator indicated she was not able to locate the information.     </li> </ol> |                                                                                     | actions to ensure that this deficiency is corrected and will not recur                                                                        |                      |  |
| G 0156<br>Bldg. 00                            | 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 3 of 7 active records reviewed in a sample of 10 (See G 158); failed to ensure the plan of care was updated to include the determination of                                                                                      | G 0156                                                                              | See G158, G159, G160, G164                                                                                                                    | 08/25/2017           |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 38 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                          |                              | ULTIPLE CO<br>JILDING | NSTRUCTION 00                                                                          | (X3) DATE<br>COMPL             |    |            |  |
|-----------------------------------------------|------------------------------------------|------------------------------|-----------------------|----------------------------------------------------------------------------------------|--------------------------------|----|------------|--|
|                                               |                                          | 15K064                       |                       | B. WING                                                                                |                                |    | 06/05/2017 |  |
|                                               |                                          |                              |                       | STREET A                                                                               | ADDRESS, CITY, STATE, ZIP CODE |    |            |  |
| NAME OF I                                     | PROVIDER OR SUPPLIEF                     | R                            |                       |                                                                                        | 82ND ST STE 216                |    |            |  |
| AT HOM                                        | E HEALTH SERVIC                          | ES LLC                       |                       | INDIAN                                                                                 | APOLIS, IN 46250               |    |            |  |
| (X4) ID                                       | SUMMARY S                                | TATEMENT OF DEFICIENCIES     |                       | ID                                                                                     | PROVIDER'S PLAN OF CORRECTION  |    | (X5)       |  |
| PREFIX                                        | 1                                        | CY MUST BE PRECEDED BY FULL  |                       | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                                | TE | COMPLETION |  |
| TAG                                           |                                          | LSC IDENTIFYING INFORMATION) | +                     | TAG                                                                                    | DEFICIENCY)                    |    | DATE       |  |
|                                               |                                          | e health aide visits         |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | inent to the patient's       |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | 7 active records             |                       |                                                                                        |                                |    |            |  |
|                                               | _                                        | ents with home health        |                       |                                                                                        |                                |    |            |  |
|                                               | _                                        | e of 10; failed to include   |                       |                                                                                        |                                |    |            |  |
|                                               | _                                        | killed nursing to obtain     |                       |                                                                                        |                                |    |            |  |
|                                               | 1                                        | ns in 7 out of 8 active      |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | d in a sample of 10;         |                       |                                                                                        |                                |    |            |  |
|                                               | _                                        | a patient's personal         |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | ces to be provided on the    |                       |                                                                                        |                                |    |            |  |
|                                               | plan of care in 1 of 5 home visits       |                              |                       |                                                                                        |                                |    |            |  |
|                                               | conducted; failed to update a medication |                              |                       |                                                                                        |                                |    |            |  |
|                                               | profile in 2 out of                      | of 8 active records          |                       |                                                                                        |                                |    |            |  |
|                                               | reviewed, failed                         | to include g-tube site       |                       |                                                                                        |                                |    |            |  |
|                                               | care, the amount                         | and frequency of water       |                       |                                                                                        |                                |    |            |  |
|                                               | flushes, the nam                         | e, amount, and frequency     |                       |                                                                                        |                                |    |            |  |
|                                               | of tube feedings,                        | , and instruction on the     |                       |                                                                                        |                                |    |            |  |
|                                               | use of the Trilog                        | y vent and bypap             |                       |                                                                                        |                                |    |            |  |
|                                               | machine for oxy                          | gen rescue in 1 of 1         |                       |                                                                                        |                                |    |            |  |
|                                               | record reviewed                          | of a patient with g-tube     |                       |                                                                                        |                                |    |            |  |
|                                               | and a vent / bypa                        | ap machine; and failed to    |                       |                                                                                        |                                |    |            |  |
|                                               | include other en                         | tities / agencies assisting  |                       |                                                                                        |                                |    |            |  |
|                                               | with the patients                        | care in 2 out of 4 active    |                       |                                                                                        |                                |    |            |  |
|                                               | records of patien                        | its with more than one       |                       |                                                                                        |                                |    |            |  |
|                                               | service in a samp                        | ple of 10 (See G 159);       |                       |                                                                                        |                                |    |            |  |
|                                               | failed to ensure                         | physicians were              |                       |                                                                                        |                                |    |            |  |
|                                               | consulted after a                        | n evaluation visit and       |                       |                                                                                        |                                |    |            |  |
|                                               | approved the Re                          | gistered Nurse               |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | s for admission in 7 of 8    |                       |                                                                                        |                                |    |            |  |
|                                               | records reviewed                         | d of patients admitted       |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | sample of 10 (See G          |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | to ensure that the           |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | otified of a patient's early |                       |                                                                                        |                                |    |            |  |
|                                               |                                          | f 2 records reviewed of      |                       |                                                                                        |                                |    |            |  |
|                                               |                                          |                              |                       |                                                                                        |                                |    |            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 39 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                    | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                          | ONSTRUCTION <u>00</u>                                                                                                                                                                                                                                                                                                                                                                                         | (X3) DATE SURVEY COMPLETED 06/05/2017 |  |  |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|--|
|                          | PROVIDER OR SUPPLIER                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                                                                                               |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                      | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                                                                                                                                                                                                 | (X5) COMPLETION DATE                  |  |  |
|                          | discharged patier (See G 164).                                                                                                                      | nts in a sample of 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                               |                                       |  |  |
|                          | problem resulted of compliance w Participation 484 Patients, Plan of Supervision.  The cumulative of problems resulted                              | effect of these systemic d in the home health y to ensure the provision                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                               |                                       |  |  |
| G 0158<br>Bldg. 00       | SUPER Care follows a writestablished and podoctor of medicinemedicine.                                                                              | eriodically reviewed by a e, osteopathy, or podiatric                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C 0159                                                                              | Director of Nursing will in-serv                                                                                                                                                                                                                                                                                                                                                                              | ice 09/25/2017                        |  |  |
|                          | the agency failed<br>the plan of care is<br>and duration of p<br>care, and providing<br>physician's order<br>reviewed in a sail<br>Findings include | review and interview, It to ensure staff followed In relation to frequency Patient visits, personal Ing services without a In 3 of 7 active records Imple of 10. (#3, 4 and 6) It is It is a service of the service of t | G 0158                                                                              | nurses on requirement to follo Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. visit is not made, nurse will document reason, complete a missed visit report and notify for missed visit. If patient requi a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes the | w If a MD res t                       |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 40 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                           | (X2) MULTIPLE CONSTRUCTION    |                       |                                                                    | (X3) DATE SURVEY                                                                       |           |     |
|------------------------------------------------------|-------------------------------------------|-------------------------------|-----------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------|-----|
| AND PLAN                                             | OF CORRECTION                             | IDENTIFICATION NUMBER:        | A. BUILDING <u>00</u> |                                                                    |                                                                                        | COMPLETED |     |
|                                                      |                                           | 15K064                        | B. WING 06/05/2017    |                                                                    |                                                                                        |           |     |
|                                                      |                                           |                               |                       | STREET A                                                           | ADDRESS, CITY, STATE, ZIP CODE                                                         |           |     |
| NAME OF F                                            | PROVIDER OR SUPPLIER                      | 8                             |                       |                                                                    | 82ND ST STE 216                                                                        |           |     |
| AT HOM                                               | E HEALTH SERVIC                           | CES LLC                       |                       |                                                                    | APOLIS, IN 46250                                                                       |           |     |
| (X4) ID                                              | SUMMARY S                                 | TATEMENT OF DEFICIENCIES      |                       | ID PROVIDER'S PLAN OF CORRECTION  FACH CORRECTIVE ACTION SHOULD BE |                                                                                        | (X        | (5) |
| PREFIX                                               |                                           | ICY MUST BE PRECEDED BY FULL  |                       | PREFIX                                                             | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | E COMPL   |     |
| TAG                                                  |                                           | LISC IDENTIFYING INFORMATION) |                       | TAG                                                                |                                                                                        | 5.11      | Œ   |
|                                                      |                                           | ncluded a plan of care for    |                       |                                                                    | is something needed that is no on the Plan of Care, LPN will                           | t         |     |
|                                                      | the certification period of 03/28/17 to   |                               |                       |                                                                    | contact he RN case manager                                                             | or        |     |
|                                                      | 5/26/17, with or                          | ders for skilled nursing      |                       |                                                                    | Director of Nursing to discuss                                                         |           |     |
|                                                      | every 14 days fo                          | or medication set up.         |                       |                                                                    | patient's need before MD is                                                            |           |     |
|                                                      | Review of the sl                          | killed nursing visit notes    |                       |                                                                    | contacted. (To be completed b                                                          | у         |     |
|                                                      | in the electronic                         | clinical record, the          |                       |                                                                    | 8/25/17)                                                                               |           |     |
|                                                      | patient record co                         | ontained a skilled nursing    |                       |                                                                    | Director of Nursing will be responsible to ensure orientati                            | n         |     |
|                                                      | 1 ^                                       | 29/17, 4/21/17, 5/5/17,       |                       |                                                                    | of newly hired nurses includes                                                         |           |     |
|                                                      | 5/18/17, and 5/23/17. The clinical record |                               |                       |                                                                    | training on requirement to follo                                                       |           |     |
|                                                      |                                           | ee a skilled nursing visit    |                       |                                                                    | Plan of Care which includes                                                            |           |     |
|                                                      | between 04/09/1                           |                               |                       |                                                                    | frequency and duration for                                                             |           |     |
|                                                      | between 6476971                           | 1 10 4/13/17.                 |                       |                                                                    | disciplines ordered by MD and                                                          |           |     |
|                                                      | 2 The climical r                          | social for notions #1         |                       |                                                                    | was tasks nurse is to provide. visit is not made, nurse will                           | та        |     |
|                                                      |                                           | record for patient #4,        |                       |                                                                    | document reason, complete a                                                            |           |     |
|                                                      |                                           | cluded a plan of care for     |                       |                                                                    | missed visit report and notify N                                                       | 1D        |     |
|                                                      |                                           | period of 4/24/17 to          |                       |                                                                    | of missed visit. If patient require                                                    | es        |     |
|                                                      | · ·                                       | ders for a licensed           |                       |                                                                    | a task that is not listed on the                                                       |           |     |
|                                                      | _                                         | LPN) up to 3 hours per        |                       |                                                                    | Plan of care, nurse will contact                                                       |           |     |
|                                                      | day, 5 days a we                          | eek to assist with personal   |                       |                                                                    | MD and obtain an order for the needed task. If LPN notes then                          |           |     |
|                                                      | care, transfers, n                        | nedication reminders,         |                       |                                                                    | is something needed that is no                                                         |           |     |
|                                                      | meal preparation                          | n / setup, and light          |                       |                                                                    | on the Plan of Care, LPN will                                                          |           |     |
|                                                      | housekeeping.                             |                               |                       |                                                                    | contact he RN case manager                                                             | or        |     |
|                                                      |                                           |                               |                       |                                                                    | Director of Nursing to discuss                                                         |           |     |
|                                                      | A. During a                               | a home visit on 6/1/17 at     |                       |                                                                    | patient's need before MD is                                                            | 7)        |     |
|                                                      |                                           | PN was observed to            |                       |                                                                    | contacted. (To begin by 8/25/1 Director of Nursing/designee v                          |           |     |
|                                                      |                                           | d dilantin (anti-seizure      |                       |                                                                    | audit 100% of nursing                                                                  |           |     |
|                                                      | _                                         | enol and ibuprofen (used      |                       |                                                                    | documentation weekly, until                                                            |           |     |
|                                                      | for mild pain an                          | • •                           |                       |                                                                    | 100% compliance is achieved,                                                           |           |     |
|                                                      | •                                         | 00 ml (milliliters) of        |                       |                                                                    | monitor compliance with follow                                                         | ing       |     |
|                                                      |                                           | ugh the patient's gastric     |                       |                                                                    | frequency and duration for disciplines ordered by MD as v                              | اامر      |     |
|                                                      |                                           |                               |                       |                                                                    | MD ordered plan of care and t                                                          |           |     |
|                                                      |                                           | fore, during, and after       |                       |                                                                    | care provided follows the MD                                                           |           |     |
|                                                      |                                           | inistration. In the           |                       |                                                                    | ordered Plan of Care. Once 10                                                          |           |     |
|                                                      | _                                         | of paper that was secured     |                       |                                                                    | compliance is achieved, Direct                                                         | or        |     |
|                                                      |                                           | r contained a list of         |                       |                                                                    | of Nursing/designee will audit                                                         |           |     |
|                                                      | medications and                           | water flushes with times      |                       |                                                                    | 25% of nursing documentation                                                           |           |     |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 41 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                  | (X2) MULTIPLE CONSTRUCTION   |       |          | (X3) DATE SURVEY                                                    |           |            |
|------------------------------------------------------|------------------------------------------------------------------|------------------------------|-------|----------|---------------------------------------------------------------------|-----------|------------|
| AND PLAN                                             | OF CORRECTION                                                    | IDENTIFICATION NUMBER:       | A. BU | JILDING  | 00                                                                  | COMPLETED |            |
|                                                      |                                                                  | 15K064                       | B. W  | ING      |                                                                     | 06/05/2   | 2017       |
|                                                      |                                                                  |                              |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                      |           |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                             | 8                            |       | 1        | 82ND ST STE 216                                                     |           |            |
| AT HOM                                               | E HEALTH SERVIC                                                  | CES LLC                      |       |          | APOLIS, IN 46250                                                    |           |            |
| (X4) ID                                              |                                                                  | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                       |           | (X5)       |
| PREFIX                                               | `                                                                | ICY MUST BE PRECEDED BY FULL |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE        | COMPLETION |
| TAG                                                  | +                                                                | LSC IDENTIFYING INFORMATION) |       | TAG      | DEFICIENCY)                                                         |           | DATE       |
|                                                      |                                                                  | he LPN indicated the         |       |          | monthly to monitor for continue                                     |           |            |
|                                                      | spouse would so                                                  | metimes have the             |       |          | compliance. (To begin 8/25/17 Director of Nursing/designee v        |           |            |
|                                                      | medications adm                                                  | ninistered prior to their    |       |          | instruct clinical staff, if patient                                 |           |            |
|                                                      | arrival and some                                                 | etimes the clinical staff    |       |          | receiving services thru more th                                     |           |            |
|                                                      | would have to ac                                                 | dminister. The LPN           |       |          | one payer, to indicate on visit                                     |           |            |
|                                                      | indicated she wo                                                 | ould provide g-tube site     |       |          | note which payer this visit is fo                                   | or.       |            |
|                                                      |                                                                  | tient received a bath.       |       |          | (To be completed by 8/25/17)                                        |           |            |
|                                                      |                                                                  | <del></del>                  |       |          | Director of Nursing will be responsible to ensure orientati         | on        |            |
|                                                      | R Review                                                         | of the skilled nursing visit |       |          | of newly hired clinical staff                                       |           |            |
|                                                      | notes indicated the following:  1. On 4/27, 4/28, 5/2, 5/3, 5/4, |                              |       |          | includes training on, if patient                                    | s         |            |
|                                                      |                                                                  |                              |       |          | receiving services thru more th                                     | nan       |            |
|                                                      |                                                                  |                              |       |          | one payer, to indicate on visit                                     |           |            |
|                                                      |                                                                  |                              |       |          | note which payer this visit is fo                                   | or.       |            |
|                                                      |                                                                  | 0, 5/11, 5/15, 5/16, 5/17,   |       |          | (To begin by 8/25/17) Director of Nursing/designee v                | vill      |            |
|                                                      |                                                                  | 5/24, 5/25, 5/30, 5/31,      |       |          | audit 100% of visit notes, weel                                     |           |            |
|                                                      | 6/1 and 6/2/17, t                                                | he visit notes indicated     |       |          | for patients receiving visits thre                                  | -         |            |
|                                                      | the skilled nurse                                                | administered tube            |       |          | multiple payers to monitor                                          |           |            |
|                                                      | feedings.                                                        |                              |       |          | compliance with marking paye                                        |           |            |
|                                                      |                                                                  |                              |       |          | on documentation. Once 100%                                         |           |            |
|                                                      | 2. On 3                                                          | 5/8, 5/9, 5/10, 5/11, 5/15,  |       |          | compliance is achieved, Direct                                      | or        |            |
|                                                      |                                                                  | 5/30, 5/31, 6/1 and          |       |          | of Nursing/designee will audit 25% of visit notes, monthly, to      |           |            |
|                                                      |                                                                  | notes indicated the          |       |          | monitor for compliance. (To be                                      |           |            |
|                                                      | *                                                                | ninistered water flushes.    |       |          | by 8/25/17)                                                         | <u> </u>  |            |
|                                                      | Skilled harbe dul                                                | ministered water flushes.    |       |          | The Director of Nursing will be                                     |           |            |
|                                                      | 3 On 5                                                           | /25, 5/30, 5/31, 6/1 and     |       |          | responsible for monitoring the                                      |           |            |
|                                                      |                                                                  |                              |       |          | corrective actions to ensure the this deficiency is corrected and   |           |            |
|                                                      |                                                                  | notes indicated the          |       |          | will not recur.                                                     | 1         |            |
|                                                      | skilled nurse pro                                                | ovided g-tube site care.     |       |          | Will flot rood.                                                     |           |            |
|                                                      |                                                                  |                              |       |          |                                                                     |           |            |
|                                                      |                                                                  | /4, 5/17, 5/25, 5/31, 6/1,   |       |          |                                                                     |           |            |
|                                                      |                                                                  | visit notes indicated the    |       |          |                                                                     |           |            |
|                                                      | skilled nurse wa                                                 | s in the home for 4 hours    |       |          |                                                                     |           |            |
|                                                      | and for 10 hours                                                 | on 5/23/17.                  |       |          |                                                                     |           |            |
|                                                      |                                                                  |                              |       |          |                                                                     |           |            |
|                                                      | 5. Thre                                                          | e (3) skilled nursing visits |       |          |                                                                     |           |            |
|                                                      | were made week                                                   |                              |       |          |                                                                     |           |            |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | OF CORRECTION  OF CORRECTION  15K064                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING                                          | onstruction <u>00</u>                                                                                                  | (X3) DATE SURVEY COMPLETED 06/05/2017 |  |  |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|--|
|                          | PROVIDER OR SUPPLIER E HEALTH SERVICES LLC                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                        |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE                  |  |  |
|                          | certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period.                                                                                                                                                                                                                                                   |                                                                                     |                                                                                                                        |                                       |  |  |
|                          | 6. On 4/25, 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23 and 5/24/17, failed to evidence if personal care had been provided.                                                                                                                                                                                       |                                                                                     |                                                                                                                        |                                       |  |  |
|                          | The skilled nurses failed to follow the plan of care in regards to frequency and duration of visits, providing personal care, as well as providing services without a physician's order.                                                                                                                                                                       |                                                                                     |                                                                                                                        |                                       |  |  |
|                          | 3. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week.                                                                              |                                                                                     |                                                                                                                        |                                       |  |  |
|                          | A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the patient's urostomy wafer had been changed weekly. The skilled nurse failed to follow the plan of care. |                                                                                     |                                                                                                                        |                                       |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 43 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                         | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                | ONSTRUCTION  00                                                                                               | (X3) DATE SI<br>COMPLE<br>06/05/2 | TED                        |  |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------|--|
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                               |                                   |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE.                               | (X5)<br>COMPLETION<br>DATE |  |
|                          | Services and Em Assistant Director had no further in documentation in findings on 6/2/15. Employee A, Administrator ar on 6/5/17 at 3:50 of hours may be being included in Authorization had there is no delined. An undated p Care" C - 580, in care is a dynamic the care, treatment provided The Care is based on assessment and in the client / famil member The I completed in full frequency, and defined the completed in full frequency, and defined the complete in full frequency. | the Alternate and Employee B, indicated b p.m., that the overage due to waiver hours and the Medicaid Prior burs. Both indicated |                                                                                           |                                                                                                               |                                   |                            |  |
| G 0159                   | 484.18(a)<br>PLAN OF CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                  |                                                                                           |                                                                                                               |                                   |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 44 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                  | ì ′ | ILDING              | nstruction<br><u>00</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X3) DATE<br>COMPL<br><b>06/05</b> /     | ETED                       |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------|
| AT HOMI                  | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                           |     | 6525 E              | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                         |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ΓE                                       | (X5)<br>COMPLETION<br>DATE |
| Bldg. 00                 | with the agency st diagnoses, includi services and equip of visits, prognosis functional limitatio nutritional requirer treatments, any sa against injury, inst discharge or referrappropriate items. Based on record the agency failed care was updated determination of aide visits specification patient's needs in records reviewed patients with hor sample of 10; fair parameters for shoxygen saturation records reviewed in a sample of 10 patient's personal be provided on thome visits condupdate a medical active records reto include g-tube and frequency of amount, and frequency of amount, and frequency of and instruction of vent and bypap rescue in 1 of 1 medical services. | review and interview, I to ensure the plan of I to include the I duration of home health I ic and pertinent to the I do out of 7 active I (#2, 3, 4, 5, 7 and 8) of The health aides in a | G 0 | 159                 | Director of Nursing/designee winstruct nurses when patient had order for home health aide to indicate who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurse should indicate if patient is cognitive to make own persona care decisions. If not then indicate who determines time-caregiver, RN, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientati of newly hired nurses includes instructing nurses when patienthas order for home health aide indicate who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurse should indicate if patient is cognitive to make own persona care decisions. If not then indicate who determines time-caregiver, RN, etc. (To begin to 8/25/17) Director of Nursing/designee waudit, weekly, 100% of Plans of Care to monitor for compliance | as  ses al  on at eto ses al  oy vill of | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 45 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                              | (X2) MULTIPLE CONSTRUCTION   |                |          | (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |  |
|------------------------------------------------------|----------------------------------------------|------------------------------|----------------|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| AND PLAN                                             | OF CORRECTION                                | IDENTIFICATION NUMBER:       | A. BUILDING 00 |          | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | COMPLETED                                    |  |
|                                                      |                                              | 15K064                       | B. WING        |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 06/05/2017                                   |  |
|                                                      |                                              |                              |                | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
| NAME OF P                                            | PROVIDER OR SUPPLIER                         |                              |                |          | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |  |
| AT HOME                                              | E HEALTH SERVIC                              | ESILC                        |                |          | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |  |
| ATTIONI                                              | E HEALTH SERVIC                              |                              |                | INDIAN   | AFOLIS, IN 40250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |  |
| (X4) ID                                              |                                              | FATEMENT OF DEFICIENCIES     |                | ID       | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X5)                                         |  |
| PREFIX                                               | ,                                            | CY MUST BE PRECEDED BY FULL  |                | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION |                                              |  |
| TAG                                                  |                                              | LSC IDENTIFYING INFORMATION) |                | TAG      | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | DATE                                         |  |
|                                                      | machine (#4); and failed to include other    |                              |                |          | with indicating who is responsi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ble                                          |  |
|                                                      | entities / agencie                           | s assisting with the         |                |          | to determine how many hours<br>patient needs when order says                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <u>,                                    </u> |  |
|                                                      | patients care in 2                           | out of 4 active records      |                |          | "up to" number of hours. Nurse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      | of patients with                             | more than one service in     |                |          | should indicate if patient is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ,3                                           |  |
|                                                      | a sample of 10.                              |                              |                |          | cognitive to make own persona                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | al                                           |  |
|                                                      | a sample of 10.                              | (ii o ana ii)                |                |          | care decisions. If not then                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |  |
|                                                      | Eindings in al. 1-                           |                              |                |          | indicate who determines time -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      | Findings include                             |                              |                |          | caregiver, RN, etc. Once 100%                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                              |  |
|                                                      |                                              |                              |                |          | compliance is achieved, Direct                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | tor                                          |  |
|                                                      |                                              | ecord for patient #2,        |                |          | of Nursing/designee will audit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4-                                           |  |
|                                                      | SOC (start of car                            | re) 3/6/12, included a       |                |          | 25% of Plans of Care monthly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                              |  |
|                                                      | plan of care for the certification period of |                              |                |          | monitor for compliance. (To be by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | giii                                         |  |
|                                                      | 4/9/17 to 6/7/17.                            |                              |                |          | Director of Nursing/designee w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | vill                                         |  |
|                                                      |                                              |                              |                |          | instruct nurses to indicate on F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |  |
|                                                      | A The nlan                                   | of care indicated home       |                |          | of Care the following: the corre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ect                                          |  |
|                                                      | _                                            | to 8 hours per day, 5        |                |          | address, status of others living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ·                                            |  |
|                                                      | •                                            |                              |                |          | the home, what tasks are to be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      |                                              | The durations of hours       |                |          | provided by staff and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              |  |
|                                                      | _                                            | nt specific and include      |                |          | when(nursing/aide). (To be completed by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |  |
|                                                      |                                              | rs per day for the home      |                |          | Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |  |
|                                                      | health aide to be                            | in the home and who          |                |          | responsible to ensure newly hi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | red                                          |  |
|                                                      | would determine                              | ed the duration of hours     |                |          | nurses are trained to indicate of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                              |  |
|                                                      | in a day should t                            | he home health aide not      |                |          | Plan of Care the following: the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |  |
|                                                      | be needed for the                            |                              |                |          | correct address, status of othe                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | rs                                           |  |
|                                                      |                                              |                              |                |          | living in the home, what tasks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      | R The plan                                   | of care indicated skilled    |                |          | to be provided by staff and wh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      | •                                            | oxygen saturations as        |                |          | (nursing/aide). (To be begin by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | /                                            |  |
|                                                      |                                              | , 0                          |                |          | 8/25/17) Director of Nursing/designee w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | uill l                                       |  |
|                                                      | •                                            | n of care failed to          |                |          | audit, weekly, 100% of Plans of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |  |
|                                                      | indicate when to                             | obtain oxygen                |                |          | Care to monitor for compliance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      | saturations.                                 |                              |                |          | indicating the Plan of Care has                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |  |
|                                                      |                                              |                              |                |          | the following: the correct addre                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ess,                                         |  |
|                                                      | C. A home                                    | visit on 6/1/17 at 9:15      |                |          | status of others living in the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |  |
|                                                      | a.m., was conduc                             | cted at the patient's        |                |          | home, what tasks are to be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |  |
|                                                      | · ·                                          | where the patient had        |                |          | provided by staff and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 0/                                           |  |
|                                                      |                                              | the new address of           |                |          | when(nursing/aide). Once 100 compliance is achieved, Direct                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |  |
|                                                      | _                                            |                              |                |          | of Nursing/designee will audit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | loi                                          |  |
|                                                      | residence was no                             | ot listed on the plan of     | 1              |          | or real sing/designed will addit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1                                            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) M                       | (X2) MULTIPLE CONSTRUCTION      |          |                                                                     | (X3) DATE SURVEY |            |
|------------------------------------------------------|----------------------|------------------------------|---------------------------------|----------|---------------------------------------------------------------------|------------------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BUILDING <u>00</u> COMPLETE. |          |                                                                     | ETED             |            |
|                                                      |                      | 15K064                       | B. W                            | B. WING  |                                                                     | 06/05/2017       |            |
|                                                      |                      |                              | <u> </u>                        | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                      |                  |            |
| NAME OF F                                            | PROVIDER OR SUPPLIEF | 8                            |                                 |          | 82ND ST STE 216                                                     |                  |            |
| AT HOM                                               | E HEALTH SERVIC      | ES LLC                       |                                 |          | APOLIS, IN 46250                                                    |                  |            |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES     |                                 | ID       | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |
| PREFIX                                               | `                    | CY MUST BE PRECEDED BY FULL  |                                 | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION) |                                 | TAG      | DEFICIENCY)                                                         |                  | DATE       |
|                                                      | •                    | of care included a former    |                                 |          | 25% of Plans of Care monthly                                        |                  |            |
|                                                      | address where se     | ervices were initially       |                                 |          | monitor for compliance. (To be by 8/25/17)                          | gin              |            |
|                                                      | provided. Durii      | ng this time, the home       |                                 |          | Director of Nursing/designee v                                      | vill             |            |
|                                                      | health aide indic    | ated the patient use to      |                                 |          | instruct nurses that a verbal or                                    |                  |            |
|                                                      | live with the son    | but moved in with the        |                                 |          | is needed from MD to make ex                                        |                  |            |
|                                                      | daughter and had     | d been residing with the     |                                 |          | visits that fall outside the order                                  |                  |            |
|                                                      | -                    | ng time and could not        |                                 |          | visit frequency for that disciplir of the Plan of Care. (To be      | ne               |            |
|                                                      |                      | the patient had moved.       |                                 |          | completed by 8/25/17)                                               |                  |            |
|                                                      |                      | a aide also indicated that   |                                 |          | Director of Nursing will be                                         |                  |            |
|                                                      | the daughter was     |                              |                                 |          | responsible to ensure orientati                                     | on               |            |
|                                                      | une daugnter was     | , disdoired.                 |                                 |          | of newly hired nurses includes                                      |                  |            |
|                                                      | 2 The clinical r     | ecord for patient #3,        |                                 |          | training on needing a verbal or                                     |                  |            |
|                                                      |                      | •                            |                                 |          | from MD to make extra visits the fall outside the ordered visit     | nat              |            |
|                                                      | · ·                  | ncluded a plan of care       |                                 |          | frequency for that discipline of                                    | the              |            |
|                                                      |                      | killed nursing every 14      |                                 |          | Plan of Care. (To begin by                                          | uic              |            |
|                                                      |                      | ion set up, oxygen           |                                 |          | 8/25/17)                                                            |                  |            |
|                                                      |                      | eded and home health         |                                 |          | Director of Nursing/designee w                                      |                  |            |
|                                                      | aide services up     | to 8 hours per day, 7        |                                 |          | track all nursing visits for a mo                                   |                  |            |
|                                                      | days a week.         |                              |                                 |          | to monitor for compliance with                                      |                  |            |
|                                                      |                      |                              |                                 |          | following ordered frequency ar<br>extra visits are noted there is a |                  |            |
|                                                      | A. On 5/31/          | /17 at 3:00 p.m.,            |                                 |          | verbal order for that visit. Once                                   |                  |            |
|                                                      | Employee C, the      | Interim Assistant            |                                 |          | 100% compliance is achieved,                                        |                  |            |
|                                                      |                      | ical Services, indicated     |                                 |          | Director of Nursing will track 2                                    |                  |            |
|                                                      |                      | extra visits to the          |                                 |          | of patients monthly to monitor                                      | for              |            |
|                                                      |                      | of fix the medication box    |                                 |          | compliance. (To begin by 8/25/17)                                   |                  |            |
|                                                      | *                    | ons not being refilled       |                                 |          | Director of Nursing is responsi                                     | ble              |            |
|                                                      | before her visit.    | and not being refined        |                                 |          | for monitoring these corrective                                     |                  |            |
|                                                      | octore her visit.    |                              |                                 |          | actions to ensure that this                                         |                  |            |
|                                                      | D 0 5/21             | 117 at 4:10 n m              |                                 |          | deficiency is corrected and will                                    |                  |            |
|                                                      |                      | 17 at 4:10 p.m.,             |                                 |          | not recur.                                                          |                  |            |
|                                                      |                      | icated she was going to      |                                 |          |                                                                     |                  |            |
|                                                      | 1                    | s home that evening and      |                                 |          |                                                                     |                  |            |
|                                                      |                      | atient had his / her         |                                 |          |                                                                     |                  |            |
|                                                      | medication for o     | ur home visit on 6/1/17.     |                                 |          |                                                                     |                  |            |
|                                                      | C. On 6/2/1          | 7 at 4:45 p.m., Employee     |                                 |          |                                                                     |                  |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 47 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                               | ILDING              | nstruction<br><u>00</u>                                                                                               | (X3) DATE<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6525 E              | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                  |                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE                          | (X5)<br>COMPLETION<br>DATE |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | did not obtain orders nor e nursing visit notes.                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                                       |                              |                            |
|                          | visit notes dated 4/29, 5/5, 5/8, 5/home health aide approximately from the plan of care include extra vising the management medications in bull duration of home to be patient speriminal hours purchased hours in a day shaide not be need and when to obtain the certification 6/22/17, with order practical nurse) and the preparation / settle housekeeping. The communication of the certification of the certific | etween scheduled visits, e health aide hours failed cific to include the er day for the home in the home as well as mined the duration of hould the home health ed for the entire 8 hours ain oxygen saturations.  ecord for patient #4, cluded a plan of care for period of 4/24/17 to ders for a LPN (licensed up to 3 hours per day, 5 ssist with personal care, ation reminders, meal up, and light. The plan of care also skilled nurse to obtain |                     |                                                                                                                       |                              |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 48 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                 | ì í                          | ULTIPLE CO.<br>JILDING | NSTRUCTION 00 | (X3) DATE<br>COMPL                                                  |        |            |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|------------------------------|------------------------|---------------|---------------------------------------------------------------------|--------|------------|
| MINDILMIN                                                                                           | or conduction                                                                   | 15K064                       | B. W                   |               | 00                                                                  | 06/05/ |            |
|                                                                                                     |                                                                                 | 1011001                      |                        | CTDEET A      | ADDRESS, CITY, STATE, ZIP CODE                                      | 00/00/ | 2011       |
| NAME OF P                                                                                           | PROVIDER OR SUPPLIEF                                                            | 2                            |                        |               | 82ND ST STE 216                                                     |        |            |
| АТ НОМІ                                                                                             | E HEALTH SERVIC                                                                 | CES LLC                      |                        |               | APOLIS, IN 46250                                                    |        |            |
| (X4) ID                                                                                             | SUMMARY S                                                                       | TATEMENT OF DEFICIENCIES     |                        | ID            | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                                                                              | ·                                                                               | CY MUST BE PRECEDED BY FULL  |                        | PREFIX        | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                                                                 |                                                                                 | LSC IDENTIFYING INFORMATION) |                        | TAG           | DEFICIENCY)                                                         |        | DATE       |
|                                                                                                     | _                                                                               | home visit on 6/1/17 at      |                        |               |                                                                     |        |            |
|                                                                                                     | • •                                                                             | Employee E, a LPN, was       |                        |               |                                                                     |        |            |
|                                                                                                     | observed to administer liquid dilantin                                          |                              |                        |               |                                                                     |        |            |
|                                                                                                     | `                                                                               | dication), tylenol and       |                        |               |                                                                     |        |            |
|                                                                                                     | • •                                                                             | for mild pain and / or       |                        |               |                                                                     |        |            |
|                                                                                                     | ,                                                                               | eximately 100 ml             |                        |               |                                                                     |        |            |
|                                                                                                     | ` ′                                                                             | rater flush through the      |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | tube (g-tube) before,        |                        |               |                                                                     |        |            |
|                                                                                                     | during, and after                                                               |                              |                        |               |                                                                     |        |            |
|                                                                                                     | administration. In the kitchen, a piece of                                      |                              |                        |               |                                                                     |        |            |
|                                                                                                     | paper that was secured to a cabinet door                                        |                              |                        |               |                                                                     |        |            |
|                                                                                                     | contained a list of medications and water flushes with times to administer. The |                              |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 |                              |                        |               |                                                                     |        |            |
|                                                                                                     | sometimes have                                                                  | icated the spouse would      |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | or to their arrival and      |                        |               |                                                                     |        |            |
|                                                                                                     | •                                                                               | linical staff would have     |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | Imployee E indicated she     |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | -tube site care after the    |                        |               |                                                                     |        |            |
|                                                                                                     | -                                                                               | a bath. Employee E and       |                        |               |                                                                     |        |            |
|                                                                                                     | •                                                                               | ssed using the Trilogy       |                        |               |                                                                     |        |            |
|                                                                                                     | -                                                                               | machine for oxygen           |                        |               |                                                                     |        |            |
|                                                                                                     | rescue.                                                                         | machine for oxygen           |                        |               |                                                                     |        |            |
|                                                                                                     | rescue.                                                                         |                              |                        |               |                                                                     |        |            |
|                                                                                                     | B. Review                                                                       | of the skilled nursing visit |                        |               |                                                                     |        |            |
|                                                                                                     | notes indicated t                                                               | <del>-</del>                 |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | <del></del>                  |                        |               |                                                                     |        |            |
|                                                                                                     | 1. On 4                                                                         | /27, 4/28, 5/2, 5/3, 5/4,    |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | 0, 5/11, 5/15, 5/16,         |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | 5/23, 5/24, 5/25, 5/30,      |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 | 2/17, the visit notes        |                        |               |                                                                     |        |            |
|                                                                                                     | •                                                                               | lled nurse administered      |                        |               |                                                                     |        |            |
|                                                                                                     | tube feedings an                                                                |                              |                        |               |                                                                     |        |            |
|                                                                                                     | <i>5</i>                                                                        |                              |                        |               |                                                                     |        |            |
|                                                                                                     |                                                                                 |                              | - 1                    |               |                                                                     |        | I          |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 49 of 247

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                    | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                          | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00                                                                                                    | (X3) DATE SURVEY COMPLETED 06/05/2017 |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------|
|                          | PROVIDER OR SUPPLIEF<br>E HEALTH SERVIC                                                                                                             |                                                                                                                                                                                                                                                   | 6525 E                                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                              | •                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                      | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                 | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | E COMPLETION                          |
|                          | 6/2/17, the visit                                                                                                                                   | /25, 5/30, 5/31, 6/1 and notes indicated the ovided g-tube site care.                                                                                                                                                                             |                                            |                                                                                                                    |                                       |
|                          | include g-tube si<br>frequency of wa<br>name, amount, a<br>feedings per g-tu<br>oxygen saturation                                                   | failed to be updated to the care, the amount and ter flushes per g-tube, the and frequency of tube tube, when to obtain the sand instruction on the sand y vent and bypap gen rescue.                                                             |                                            |                                                                                                                    |                                       |
|                          | SOC 11/21/16, i<br>the certification<br>5/19/17, with ore                                                                                           | ecord for patient #5,<br>ncluded a plan of care for<br>period of 3/19/17 to<br>ders for home health aide<br>hours per day, 5 days a                                                                                                               |                                            |                                                                                                                    |                                       |
|                          | visit notes during period, the home services approxionate hours. The durate be patient specific minimal hours purchastly aide to be would determine | of the home health aide g this certification health aide provided mately from 1.25 to 3 tions of hours failed to fic and include the er day for the home in the home and who hed the duration of hours he home health aide not he entire 6 hours. |                                            |                                                                                                                    |                                       |
|                          |                                                                                                                                                     | of care indicated skilled a oxygen saturations as                                                                                                                                                                                                 |                                            |                                                                                                                    |                                       |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 50 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUILDING 00  B. WING                                                                                                                                                                                                                                                                             |          |                     | COMPLETED 06/05/2017                                                                                                   |    |                            |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|------------------------------------------------------------------------------------------------------------------------|----|----------------------------|
|                                                       | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                     | <u> </u> | 6525 E              | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                       |    |                            |
| AT HOM                                                | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CES LLC                                                                                                                                                                                                                                                                                             |          | INDIAN              | APOLIS, IN 46250                                                                                                       |    |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                   |          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΤE | (X5)<br>COMPLETION<br>DATE |
|                                                       | needed. The pla<br>indicate when to<br>saturations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | n of care failed to<br>obtain oxygen                                                                                                                                                                                                                                                                |          |                     |                                                                                                                        |    |                            |
|                                                       | SOC 1/30/17, in the certification 5/29/17, with order to be administer. Wednesday, and flush and order for the certification of the cer | ecord for patient #6, neluded a plan of care for period of 3/31/17 to ders for skilled nursing 1 to 2 hours per visit, 3 for the instillation of gation solution via dder every visit. The le evidenced Clorpactined every Monday, Friday via urostomy for skilled nursing to aturations as needed. |          |                     |                                                                                                                        |    |                            |
|                                                       | notes on 3/31, 4/4/14, 4/12, 4/19, 5/1, 5/3, 5/5, 5/8 5/19, 5/22, 5/24, visit notes failed instillation of the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | of the skilled nursing visit 73, 4/5, 4/7, 4/10, 4/12, 4/21, 4/24, 4/26, 4/28, 5/10, 5/12, 5/15, 5/17, 5/26, and 5/29/17, the to evidence that the e medication / irrigation eter into the bladder had                                                                                              |          |                     |                                                                                                                        |    |                            |
|                                                       | was interviewed indicated the pat instillation into t discontinued. T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | cetor of Clinical Services<br>on 06/05/17 at 1:30 and<br>ient's Clorpactin<br>he bladder had been<br>he Director of Clinical<br>ed a physician's script /                                                                                                                                           |          |                     |                                                                                                                        |    |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 51 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                | r í                                                                                                                                                                                                                                              | IULTIPLE CO<br>UILDING | NSTRUCTION 00 | (X3) DATE<br>COMPL                                                 |        |                    |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------|--------------------------------------------------------------------|--------|--------------------|--|
|                                               |                                                                                                                                                                | 15K064                                                                                                                                                                                                                                           | B. W                   | ING           | <u> </u>                                                           | 06/05/ |                    |  |
| NAME OF I                                     | DOWNER OR CURRUSE                                                                                                                                              |                                                                                                                                                                                                                                                  |                        | STREET A      | DDRESS, CITY, STATE, ZIP CODE                                      |        |                    |  |
|                                               | ROVIDER OR SUPPLIER                                                                                                                                            |                                                                                                                                                                                                                                                  |                        |               | 82ND ST STE 216                                                    |        |                    |  |
| AT HOM                                        | E HEALTH SERVIC                                                                                                                                                | CES LLC                                                                                                                                                                                                                                          |                        | INDIAN        | APOLIS, IN 46250                                                   |        |                    |  |
| (X4) ID                                       |                                                                                                                                                                | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                         |                        | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)<br>COMPLETION |  |
| PREFIX<br>TAG                                 | •                                                                                                                                                              | CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)                                                                                                                                                                                        |                        | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   |        |                    |  |
|                                               | order dated 3/2/1                                                                                                                                              | <u> </u>                                                                                                                                                                                                                                         |                        |               |                                                                    |        |                    |  |
|                                               |                                                                                                                                                                | Clorpactin instillation.                                                                                                                                                                                                                         |                        |               |                                                                    |        |                    |  |
|                                               | C. A. Durin at 9:30 a.m., the live in a group h  The plan of care exclude the Clor instillation / irrig when to obtain of failed to include                    | ng a home visit on 6/2/17 patient was observed to                                                                                                                                                                                                |                        |               |                                                                    |        |                    |  |
|                                               | 6. The clinical r<br>SOC 12/31/16, is<br>the certification<br>6/7/17, with order                                                                               | ecord for patient #7,<br>ncluded a plan of care for<br>period of 4/9/17 to<br>ers for home health aide<br>hours per day, 7 days a                                                                                                                |                        |               |                                                                    |        |                    |  |
|                                               | visit notes during<br>period, the home<br>services approxi-<br>hours. The dura<br>be patient specif<br>minimal hours p<br>health aide to be<br>would determine | of the home health aide g this certification health aide provided mately from 3.5 to 6 tions of hours failed to fic and include the er day for the home in the home and who had the duration of hours he home health aide not he entire 6 hours. |                        |               |                                                                    |        |                    |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 52 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED |       |              |                                                                    |        |                    |
|------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------|-------|--------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN                                             | OF CORRECTION                         | IDENTIFICATION NUMBER:                                               |       |              | 00                                                                 |        |                    |
|                                                      |                                       | 15K064                                                               | B. W. | ING          |                                                                    | 06/05/ | 2017               |
| NAME OF F                                            | PROVIDER OR SUPPLIEF                  | <b>\</b>                                                             |       |              | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
|                                                      | E HEALTH SERVIC                       | SEC II C                                                             |       |              | 82ND ST STE 216<br>APOLIS, IN 46250                                |        |                    |
|                                                      |                                       |                                                                      |       |              | AFOLIS, IN 40250                                                   |        |                    |
| (X4) ID<br>PREFIX                                    |                                       | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL                |       | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)<br>COMPLETION |
| TAG                                                  | ,                                     | LSC IDENTIFYING INFORMATION)                                         |       | TAG          | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                      | TE     | DATE               |
|                                                      | B The plan                            | of care indicated skilled                                            |       |              |                                                                    |        |                    |
|                                                      | •                                     | n oxygen saturations as                                              |       |              |                                                                    |        |                    |
|                                                      | _                                     | n of care failed to                                                  |       |              |                                                                    |        |                    |
|                                                      | indicate when to obtain oxygen        |                                                                      |       |              |                                                                    |        |                    |
|                                                      |                                       | saturations.                                                         |       |              |                                                                    |        |                    |
|                                                      |                                       |                                                                      |       |              |                                                                    |        |                    |
|                                                      | C. Review of a recertification        |                                                                      |       |              |                                                                    |        |                    |
|                                                      | comprehensive a                       | comprehensive assessment dated 4/7/17,                               |       |              |                                                                    |        |                    |
|                                                      | the "Professional Services" narrative |                                                                      |       |              |                                                                    |        |                    |
|                                                      | section indicated                     | I the patient was                                                    |       |              |                                                                    |        |                    |
|                                                      | receiving home                        | health services with a                                               |       |              |                                                                    |        |                    |
|                                                      | Medicare agency for wound treatments. |                                                                      |       |              |                                                                    |        |                    |
|                                                      | The plan of care                      | failed to evidence that                                              |       |              |                                                                    |        |                    |
|                                                      | the patient's wou                     | inds were being managed                                              |       |              |                                                                    |        |                    |
|                                                      | by a Medicare ag                      | gency.                                                               |       |              |                                                                    |        |                    |
|                                                      |                                       |                                                                      |       |              |                                                                    |        |                    |
|                                                      | 7. The clinical r                     | record for patient #8,                                               |       |              |                                                                    |        |                    |
|                                                      | SOC 8/3/16, inc.                      | luded a plan of care for                                             |       |              |                                                                    |        |                    |
|                                                      | the certification                     | period of 3/31/17 to                                                 |       |              |                                                                    |        |                    |
|                                                      | 5/29/17, with ore                     | ders for home health aide                                            |       |              |                                                                    |        |                    |
|                                                      | services up to 8                      | hours per day, 7 days a                                              |       |              |                                                                    |        |                    |
|                                                      | week.                                 |                                                                      |       |              |                                                                    |        |                    |
|                                                      |                                       |                                                                      |       |              |                                                                    |        |                    |
|                                                      |                                       | of the home health aide                                              |       |              |                                                                    |        |                    |
|                                                      |                                       | g this certification                                                 |       |              |                                                                    |        |                    |
|                                                      | _                                     | e health aide provided                                               |       |              |                                                                    |        |                    |
|                                                      |                                       | mately from 3.50 to 8                                                |       |              |                                                                    |        |                    |
|                                                      |                                       | tions of hours failed to                                             |       |              |                                                                    |        |                    |
|                                                      |                                       | ic and include the                                                   |       |              |                                                                    |        |                    |
|                                                      | •                                     | er day for the home                                                  |       |              |                                                                    |        |                    |
|                                                      |                                       | in the home and who                                                  |       |              |                                                                    |        |                    |
|                                                      |                                       | ed the duration of hours                                             |       |              |                                                                    |        |                    |
|                                                      | _                                     | the home health aide not                                             |       |              |                                                                    |        |                    |
|                                                      | be needed for the                     | e entire 8 hours.                                                    |       |              |                                                                    |        |                    |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 53 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                   | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                  |                      |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | ROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                              | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                                 |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                                                                            | nursing to obtain<br>needed. The pla<br>indicate when to<br>saturations.  8. Employee B,<br>Services and Em<br>Alternate Director<br>had no further in                                                                                                                                                                                                                                                                                                 | the Director of Clinical aployee C, the Interim or of Clinical Services, aformation or n relation to the above 17 at 4:00 p.m.                                                                                                                               |                     |                                                                                                                        |                      |
|                                                                                                            | further informati<br>the exit conferen                                                                                                                                                                                                                                                                                                                                                                                                                 | nd Employee B, had no<br>son or documentation by<br>ace on 6/5/17 at 3:50 p.m.                                                                                                                                                                               |                     |                                                                                                                        |                      |
|                                                                                                            | is required in the admission, recer change in the plate Plan of Care is be assessment and it the client / famil member The I completed in ful frequency, and design of the complete in ful frequency, and design of the complete in the complete in ful frequency, and design of the complete in ful frequency. | with a patient's physician e following cases: Upon tification or discharge an of The individualized based on a comprehensive information provided by and health team Plan of Care shall be to include Type, duration of all visits / stions, treatments, and |                     |                                                                                                                        |                      |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 54 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV          |       |                        | SURVEY                                                                                                 |          |            |
|------------------------------------------------------|--------------------------------|----------------------------------------------------|-------|------------------------|--------------------------------------------------------------------------------------------------------|----------|------------|
| AND PLAN                                             | OF CORRECTION                  | IDENTIFICATION NUMBER:                             | A. BU | JILDING                | 00                                                                                                     | COMPL    | ETED       |
|                                                      |                                | 15K064                                             | B. Wl | NG                     |                                                                                                        | 06/05/   | 2017       |
|                                                      |                                |                                                    |       | STREET A               | ADDRESS, CITY, STATE, ZIP CODE                                                                         | <u> </u> |            |
| NAME OF P                                            | ROVIDER OR SUPPLIER            |                                                    |       |                        | 82ND ST STE 216                                                                                        |          |            |
| AT HOME                                              | E HEALTH SERVIC                | ES LLC                                             |       | INDIANAPOLIS, IN 46250 |                                                                                                        |          |            |
| (X4) ID                                              | SUMMARY S                      | TATEMENT OF DEFICIENCIES                           |       | ID                     | PROVIDER'S PLAN OF CORRECTION                                                                          |          | (X5)       |
| PREFIX                                               | `                              | CY MUST BE PRECEDED BY FULL                        |       | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT                                | TE       | COMPLETION |
| TAG                                                  |                                | LSC IDENTIFYING INFORMATION)                       | -     | TAG                    | DEFICIENCY)                                                                                            |          | DATE       |
|                                                      | 11. An undated                 | policy titled "Skilled                             |       |                        |                                                                                                        |          |            |
|                                                      | Nursing Services               | s" C - 200, indicated "                            |       |                        |                                                                                                        |          |            |
|                                                      | The Registered Nurse Regularly |                                                    |       |                        |                                                                                                        |          |            |
|                                                      | reevaluates the c              | lients needs, and                                  |       |                        |                                                                                                        |          |            |
|                                                      | coordinates the r              | necessary services                                 |       |                        |                                                                                                        |          |            |
|                                                      |                                | of Care and necessary                              |       |                        |                                                                                                        |          |            |
|                                                      | revisions and up               | dates to the plan of care                          |       |                        |                                                                                                        |          |            |
|                                                      | and the care plan              | 1 "                                                |       |                        |                                                                                                        |          |            |
| G 0160                                               | 484.18(a)                      |                                                    |       |                        |                                                                                                        |          |            |
|                                                      | PLAN OF CARE                   |                                                    |       |                        |                                                                                                        |          |            |
| Bldg. 00                                             |                                | rs a patient under a plan of                       |       |                        |                                                                                                        |          |            |
|                                                      |                                | e completed until after an                         |       |                        |                                                                                                        |          |            |
|                                                      |                                | e physician is consulted to or modification to the |       |                        |                                                                                                        |          |            |
|                                                      | original plan.                 | of modification to the                             |       |                        |                                                                                                        |          |            |
|                                                      | Based on record                | review and interview,                              | G 0   | 160                    | Director of Nursing/designee w                                                                         |          | 08/25/2017 |
|                                                      | the agency failed              | I to ensure physicians                             |       |                        | in-service nurses on contacting                                                                        | g        |            |
|                                                      | were consulted a               | fter an evaluation visit                           |       |                        | MD after start of care visit to discuss visit findings, suggested plan of care to include disciplines, |          |            |
|                                                      | and approved the               | e Registered Nurse                                 |       |                        |                                                                                                        |          |            |
|                                                      | * *                            | s for admission in 7 of 8                          |       |                        | frequency and tasks. (To be                                                                            | ,        |            |
|                                                      | records reviewed               | l of patients admitted                             |       |                        | done by 8/25/17)                                                                                       |          |            |
|                                                      |                                | ample of 10. (# 1, 3, 4,                           |       |                        | Director of Nursing will be                                                                            |          |            |
|                                                      | 5, 6, 8, 9)                    | ampre of 10. (" 1, 5, 1,                           |       |                        | responsible to ensure orientati<br>of newly hired nurses includes                                      |          |            |
|                                                      | 3, 0, 0, 7)                    |                                                    |       |                        | training on contacting MD after                                                                        |          |            |
|                                                      | Findings include               | :                                                  |       |                        | start of care visit to discuss vis<br>findings, suggested plan of car                                  | sit      |            |
|                                                      | 1. The clinical re             | ecord for patient #1,                              |       |                        | to include disciplines, frequence and tasks. (To begin 8/25/17)                                        | -        |            |
|                                                      | SOC (Start of Ca               | •                                                  |       |                        | Director of Nursing/designee w                                                                         |          |            |
|                                                      | reviewed.                      | , · · · · · · · · · · · · · · · · · · ·            |       |                        | audit 100% of admissions to                                                                            |          |            |
|                                                      |                                |                                                    |       |                        | monitor for compliance with                                                                            |          |            |
|                                                      | A The clini                    | ical record evidenced an                           |       |                        | contacting MD after start of ca                                                                        | re       |            |
|                                                      |                                | ensive start of care                               |       |                        | visit to discuss visit findings, suggested plan of care to inclu                                       | ıde      |            |
|                                                      | •                              | 1 3/10/15, which failed to                         |       |                        | disciplines, frequency and task                                                                        |          |            |
|                                                      |                                | *                                                  |       |                        | Once 100% compliance has be                                                                            |          |            |
|                                                      | evidence that the              | e physician had been                               |       |                        | achieved, Director of                                                                                  |          |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 55 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |       |            | SURVEY                                                                                 |        |            |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------|------------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                           | IDENTIFICATION NUMBER:                      | A. BU | JILDING    | 00                                                                                     | COMPLI | ETED       |
|                                                      |                                                                                                                                                                         | 15K064                                      | B. W  | ING        |                                                                                        | 06/05/ | 2017       |
| NAME OF I                                            |                                                                                                                                                                         |                                             |       | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                                         |        |            |
| NAME OF E                                            | PROVIDER OR SUPPLIEF                                                                                                                                                    | C                                           |       | 6525 E     | 82ND ST STE 216                                                                        |        |            |
|                                                      | E HEALTH SERVIC                                                                                                                                                         |                                             | _     |            | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID                                              |                                                                                                                                                                         | TATEMENT OF DEFICIENCIES                    |       | ID         | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)       |
| PREFIX                                               |                                                                                                                                                                         | ICY MUST BE PRECEDED BY FULL                |       | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  |                                                                                                                                                                         | LSC IDENTIFYING INFORMATION)                |       | TAG        | ,                                                                                      | 0/     | DATE       |
|                                                      | contacted.                                                                                                                                                              |                                             |       |            | Nursing/designee will audit 25 of admissions monthly to monthly                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            | for compliance. (To begin                                                              | itoi   |            |
|                                                      | B. Review                                                                                                                                                               | of the coordination notes                   |       |            | 8/25/17)                                                                               |        |            |
|                                                      | and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation visit dated 03/10/17. |                                             |       |            | Director of Nursing will be                                                            |        |            |
|                                                      |                                                                                                                                                                         |                                             |       | I          | responsible for monitoring the                                                         |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            | corrective actions to ensure the deficiency is corrected and will                      |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        | l      |            |
|                                                      |                                                                                                                                                                         |                                             |       | not recur. |                                                                                        |        |            |
|                                                      | 2. The clinical record for patient #3, SOC 11/28/16, was reviewed.  A. The clinical record evidenced an                                                                 |                                             |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      | _                                                                                                                                                                       | ensive start of care                        |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         | d 11/28/16, which failed                    |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         | the physician had been                      |       |            |                                                                                        |        |            |
|                                                      | contacted.                                                                                                                                                              |                                             |       |            |                                                                                        |        |            |
|                                                      | D. D                                                                                                                                                                    | . (1)                                       |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         | of the coordination notes                   |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         | ders, the clinical record                   |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         | ee that the physician was                   |       |            |                                                                                        |        |            |
|                                                      | · · · · · · · · · · · · · · · · · · ·                                                                                                                                   | ed, and orders obtained                     |       |            |                                                                                        |        |            |
|                                                      | after the evaluati                                                                                                                                                      | ion / admission visit                       |       |            |                                                                                        |        |            |
|                                                      | dated 11/28/16.                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      | 3. The clinical r                                                                                                                                                       | record for patient #4,                      |       |            |                                                                                        |        |            |
|                                                      | SOC 4/24/17, wa                                                                                                                                                         | as reviewed. An order                       |       |            |                                                                                        |        |            |
|                                                      | dated 4/21/17 in                                                                                                                                                        | dicated for the skilled                     |       |            |                                                                                        |        |            |
|                                                      | nurse to evaluate                                                                                                                                                       | e for home care services                    |       |            |                                                                                        |        |            |
|                                                      | for 4/24/17.                                                                                                                                                            |                                             |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         |                                             |       |            |                                                                                        |        |            |
|                                                      | A. The clin                                                                                                                                                             | ical record evidenced an                    |       |            |                                                                                        |        |            |
|                                                      | OASIS compreh                                                                                                                                                           | ensive start of care                        |       |            |                                                                                        |        |            |
|                                                      | ^                                                                                                                                                                       | d 4/24/17, which failed to                  |       |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                         | e physician had been                        |       |            |                                                                                        |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 56 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K064 |                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                               | ONSTRUCTION  00     | COMI                                                                                                          | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |
|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
|                                                                                                           | PROVIDER OR SUPPLIEI                                                                                                                                                                                                                                                                     |                                                                                                                                          | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>NAPOLIS, IN 46250                                        | •                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                  | (EACH DEFICIEN                                                                                                                                                                                                                                                                           | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOULL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ) BE                                  | (X5)<br>COMPLETION<br>DATE |
|                                                                                                           | contacted.                                                                                                                                                                                                                                                                               |                                                                                                                                          |                     |                                                                                                               |                                       |                            |
|                                                                                                           | and physician or failed to evidence notified, consult after the evaluate dated 4/24/17.  4. The clinical in SOC 11/21/16, where the evaluate of the evaluate dated 4/24/17.  A. A physician indicated a skilled assessment and start of care  B. The clin OASIS compreheassessment dated | cian order dated 11/21/16,<br>ed nurse visit x 1 for<br>ent for home health aide                                                         |                     |                                                                                                               |                                       |                            |
|                                                                                                           | and physician or<br>failed to evidend<br>notified, consult                                                                                                                                                                                                                               | of the coordination notes<br>rders, the clinical record<br>se that the physician was<br>ed, and orders obtained<br>ion / admission visit |                     |                                                                                                               |                                       |                            |
|                                                                                                           | 5. The clinical i<br>SOC 1/30/17, w                                                                                                                                                                                                                                                      | record for patient #6, as reviewed.                                                                                                      |                     |                                                                                                               |                                       |                            |
|                                                                                                           | A. The clin                                                                                                                                                                                                                                                                              | ical record evidenced an                                                                                                                 |                     |                                                                                                               |                                       |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 57 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                  | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING                                                                                       | ONSTRUCTION  00                                                                           | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                          |    |                            |  |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----|----------------------------|--|
|                                                                                                            | PROVIDER OR SUPPLIED                                             |                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                                |    |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                   | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)                                            | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | BE | (X5)<br>COMPLETION<br>DATE |  |
|                                                                                                            | assessment date                                                  | nensive start of care<br>d 1/30/17, which failed to<br>e physician had been                                                      |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            | and physician or<br>failed to evidend<br>notified, consult       | of the coordination notes rders, the clinical record ce that the physician was ted, and orders obtained ion visit dated 1/30/17. |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            | 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. |                                                                                                                                  |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            |                                                                  | cian order dated 7/28/16, illed nursing to evaluate services.                                                                    |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            | OASIS comprehassessment date                                     | ical record evidenced an<br>nensive start of care<br>d 8/3/16, which failed to<br>e physician had been                           |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            | and physician or<br>failed to evidend<br>notified, consult       | of the coordination notes rders, the clinical record ce that the physician was ted, and orders obtained ion visit dated 8/3/16.  |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            | 7. The clinical soc 7/8/16, wa                                   | record for patient #9,<br>s reviewed.                                                                                            |                                                                                           |                                                                                                                |    |                            |  |
|                                                                                                            | A. The clin                                                      | ical record evidenced an                                                                                                         |                                                                                           |                                                                                                                |    |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 58 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                       | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                           | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00                                                                                                    | (X3) DATE :<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                |                                                                                                                                                                                                    | 6525 E                                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>NAPOLIS, IN 46250                                             |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                         | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                             | (X5)<br>COMPLETION<br>DATE |
|                          | assessment dated                                                                                                                       | ensive start of care 17/8/16, which failed to physician had been                                                                                                                                   |                                            |                                                                                                                    |                                |                            |
|                          | and physician or<br>failed to evidence<br>notified, consulte                                                                           | of the coordination notes<br>ders, the clinical record<br>e that the physician was<br>ed, and orders obtained<br>on visit dated 7/8/16.                                                            |                                            |                                                                                                                    |                                |                            |
|                          | the Employee C,<br>Director of Clini<br>Employee A, the<br>on 5/30/17 at 11<br>indicated orders<br>physician prior t<br>A and Employee | trance conference with the Interim Assistant cal Services and with Alternate Administrator 10 a.m. Employee A were obtained from admission. Employee C could not indicate if s contacted after the |                                            |                                                                                                                    |                                |                            |
|                          | Orders" C - 635,<br>Communication<br>is required in the                                                                                | with a patient's physician following cases: Upon tification or discharge                                                                                                                           |                                            |                                                                                                                    |                                |                            |
|                          | Care" C - 580, ir<br>Communication<br>is required in the                                                                               | policy titled "Plan of adicated" with a patient's physician following cases: Upon tification or discharge                                                                                          |                                            |                                                                                                                    |                                |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 59 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A. BUII<br>B. WIN                                                                                                                                                                                   | DING                                                                                      | 00                 | COMPL<br>06/05/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ETED                |                            |
|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------|
|                                                                                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                                       | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)                                                                                                                 |                                                                                           | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TE                  | (X5)<br>COMPLETION<br>DATE |
| G 0164<br>Bldg. 00                                                             | Plan of Care is be assessment and if the client / family member If a punder a Plan of Completed until a the physician sha approve addition original plan (484.18(b)) PERIODIC REVIE Agency profession physician to any conneed to alter the passed on record the agency failed physician was not discharged patient (#10)  Findings include  1. The clinical reof care) 5/11/16, included a plan of certification of 3 orders for home 1 hour a day, 7 dipersonal care, bar | W OF PLAN OF CARE al staff promptly alert the nanges that suggest a lan of care. review and interview, to ensure that the stified of a patient's early 2 records reviewed of nts in a sample of 10. | G 016                                                                                     | 54                 | Director of Nursing will in-servinursing staff on requirement to notify MD of a patient's discha and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to docum these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientati of newly hired nurses includes training on requirement to notif MD of a patient's discharge an notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to docum these conversations in patient's chart. (To begin by 8/25/17) | orge y nent s fy nd | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 60 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CONSTRUCTION  00                                                                    | COMI                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY COMPLETED 06/05/2017                      |                            |  |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------|--|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                             |                                                            |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)                                                                                                                                                                                                                                  | TION<br>ID BE<br>OPRIATE                                   | (X5)<br>COMPLETION<br>DATE |  |
|                                                                                                            | reminders and licare plan.  A. The clin discharge OASI dated 4/2/17. The cevidenced that had been notified unscheduled discurse discharge of the line in the line is required in the line in the line is required in the line | ght housekeeping per  ical record evidenced a S discharge assessment ne clinical record failed it the attending physician d of the patient's charge.  with the Employee C, of Clinical Services, on o.m., the employee cient would send aides ay, the patient called and or home health agency . At Home Health It to discharge the patient.  it 2:30 p.m., the agency ovide any further such as physician orders notes with the physician discharge upon request.  solicy titled "Physician ordicateed" with a patient's physician e following cases: Upon tification or discharge |                                                                                     | Director of Nursing/design audit 100% of discharges ensure compliance with n MD of upcoming discharg notifying other agencies ir in patient's care of patient upcoming discharge from (To begin by 8/25/17)  The Director of Nursing w responsible for monitoring corrective actions to ensure this deficiency is corrected will not recur. | to otifying e and nvolved 's agency.  ill be these re that |                            |  |
| G 0168                                                                                                     | 484.30<br>SKILLED NURSIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | NG SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                     |                                                                                                                                                                                                                                                                                                                                             |                                                            |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 61 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | r í                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | JILDING | ONSTRUCTION  00     | (X3) DATE<br>COMPL<br><b>06/05</b> /                                                                                   | ETED |                            |
|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------|------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
|                                                                                                              | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                                 |      |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                     | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE   | (X5)<br>COMPLETION<br>DATE |
|                                                                                                              | the agency failed the plan of care and duration of p care, and provide physician's order records reviewed nursing services 170); failed to en Nurse reassessed surgery in 1 out patient who receduring a certification of 10 (See G 172 plan of care was determination of aide visits specification of the patient's needs in records reviewed health aides in a include parameter obtain oxygen satisfied to updefine the profile of the profile in 2 out or reviewed; failed care, the amount flushes, the namon of tube feedings use of the Trilog | review and interview, do to ensure staff followed in relation to frequency patient visits, personal ing services without a rin 1 out of 4 active dof patients with skilled in a sample of 10 (See Gonsure that a Registered do a patient following of 1 record reviewed of a rived surgical procedure ation period in a sample 2); failed to ensure the updated to include the dout of 7 active dof patients with home sample of 10; failed to ers for skilled nursing to atturations in 7 out of 8 viewed in a sample of ate a patient's personal ces to be provided on the of 5 home visits do to update a medication of 8 active records to include g-tube site and frequency of water e, amount, and frequency and instruction on the y vent and bypap gen rescue in 1 of 1 | G 0     | 168                 | See G170, G172, G173, G186<br>G181, G183                                                                               | 0,   | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 62 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ľ í                                                                                                                                                                                                                                                                                                                                                                                                               | ULTIPLE COI<br>UILDING | NSTRUCTION<br>00 | COMPL                                                                                                       |          |                      |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------|-------------------------------------------------------------------------------------------------------------|----------|----------------------|
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15K064                                                                                                                                                                                                                                                                                                                                                                                                            | B. W                   | ING              |                                                                                                             | 06/05/   | 2017                 |
|                                               | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                   |                        | 6525 E 8         | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                        | <u> </u> |                      |
| (X4) ID<br>PREFIX<br>TAG                      | record reviewed and a vent / bypa include other ent with the patients records of patien service in a samp failed to ensure the Nurse (LPN) documents of the patients of the patients of the patients records of patients of patients of the pa | ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) of a patient with g-tube up machine; and failed to ities / agencies assisting care in 2 out of 4 active ts with more than one ble of 10 (See G 173); the License Practical cumented on a patient's                                                                                                                              |                        | ID PREFIX TAG    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ATE      | (X5) COMPLETION DATE |
|                                               | 4 active records skillned nursing 180); failed to er Practical Nurse (of care in relation duration of paties and providing se physician's order records reviewed nursing in a samuland failed to door nursing visit not administered, ou specific the med the patient, specific                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | and bowel program in 1 of reviewed of patients with in a sample of 10 (See G asure the Licensed LPN) followed the plan in to frequency and int visits, personal care, revices without a rin 2 out of 4 active 1 of patients with skilled ple of 10 (See G 181); ument in the skilled es the tube feeding tecome of the fluid intake, ication that was taught to fic diet teaching, disease , reason for physician |                        |                  |                                                                                                             |          |                      |
|                                               | notification as w<br>the material educe<br>physician notific<br>reviewed (See G                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ell as the follow up on cated with the patient and ation in 1 of 10 records                                                                                                                                                                                                                                                                                                                                       |                        |                  |                                                                                                             |          |                      |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 63 of 247

| STATEMEN | T OF DEFICIENCIES                              | X1) PROVIDER/SUPPLIER/CLIA                                                             | (X2) MU | JLTIPLE CO | NSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE S       | SURVEY     |
|----------|------------------------------------------------|----------------------------------------------------------------------------------------|---------|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------|
| AND PLAN | OF CORRECTION                                  | IDENTIFICATION NUMBER:                                                                 | A. BU   | ILDING     | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COMPL             | ETED       |
|          |                                                | 15K064                                                                                 | B. WI   | NG         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 06/05/            | 2017       |
|          | ROVIDER OR SUPPLIER                            |                                                                                        | •       | 6525 E     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   |            |
| (X4) ID  | SUMMARY S                                      | FATEMENT OF DEFICIENCIES                                                               |         | ID         | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   | (X5)       |
| PREFIX   | (EACH DEFICIEN                                 | CY MUST BE PRECEDED BY FULL                                                            |         | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ΓE                | COMPLETION |
| TAG      |                                                | LSC IDENTIFYING INFORMATION)                                                           |         | TAG        | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                   | DATE       |
|          | Services.  The cumulative of problems resulted | effect of these systemic d in the home health y to ensure the provision care in a safe |         |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                   |            |
| G 0170   | 484.30                                         |                                                                                        |         |            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                   |            |
| Bldg. 00 | SKILLED NURSING SERVICES                       |                                                                                        | G 0     | 170        | Director of Nursing will in-servinurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. visit is not made, nurse will document reason, complete a missed visit report and notify N of missed visit. (To be complet by 8/25/17) Director of Nursing will be responsible to ensure orientati of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. visit is not made, nurse will document reason, complete a missed visit report and notify N of missed visit (To begin | w If a ID ed on w | 08/25/2017 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 64 of 247

| AND PLAN OF CORRECTION DENTIFICATION NUMBER:  15K064  A. BUILDING  00  COMPLET  06/05/20  STREET ADDRESS, CITY, STATE, ZIP CODE  6525 E 82ND ST STE 216  INDIANAPOLIS, IN 46250 |                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| NAME OF PROVIDER OR SUPPLIER 6525 E 82ND ST STE 216                                                                                                                             |                    |
| 6525 E 82ND ST STE 216                                                                                                                                                          |                    |
| . (5) LIVANI LII (5) LIVANI (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)                                                                                                             |                    |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID                                                                                                                                    | (V5)               |
| PROVIDER'S PLAN OF CORRECTION                                                                                                                                                   | (X5)<br>COMPLETION |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                             | DATE               |
| 5/18/17, and 5/23/17. The clinical record audit 100% of nursing                                                                                                                 |                    |
| failed to evidence a skilled nursing visit  documentation weekly, until 100% compliance is achieved, to                                                                         |                    |
| between 04/09/17 to 4/15/17.                                                                                                                                                    |                    |
| frequency and duration for                                                                                                                                                      |                    |
| 2. Employee B, the Director of Clinical disciplines ordered by MD as well                                                                                                       |                    |
| Services and Employee C, the Interim  MD ordered plan of care and that care provided follows the MD                                                                             |                    |
| Alternate Director of Clinical Services, ordered Plan of Care. Once 100%                                                                                                        |                    |
| had no further information or compliance is achieved, Director                                                                                                                  |                    |
| documentation in relation to the above of Nursing/designee will audit 25% of nursing documentation                                                                              |                    |
| findings on 6/2/17 at 4:00 p.m.                                                                                                                                                 |                    |
| compliance. (To begin by                                                                                                                                                        |                    |
| 3. Employee A, the Alternate 8/25/17)                                                                                                                                           |                    |
| Administrator and Employee B, had no  The Director of Nursing will be responsible for monitoring these                                                                          |                    |
| corrective actions to ensure that                                                                                                                                               |                    |
| the exit conference on 6/5/17 at 3:50 p.m. this deficiency is corrected and                                                                                                     |                    |
| 4. An undated policy titled "Plan of will not recur.                                                                                                                            |                    |
| Care" C - 580, indicated " Planning for                                                                                                                                         |                    |
| care is a dynamic process that addresses                                                                                                                                        |                    |
| the care, treatment and services to be                                                                                                                                          |                    |
| provided The individualized Plan of                                                                                                                                             |                    |
| Care is based on a comprehensive                                                                                                                                                |                    |
| assessment and information provided by                                                                                                                                          |                    |
| the client / family and health team                                                                                                                                             |                    |
| member The Plan of Care shall be                                                                                                                                                |                    |
| completed in full to include Type,                                                                                                                                              |                    |
| frequency, and duration of all visits /                                                                                                                                         |                    |
| services, Medications, treatments, and                                                                                                                                          |                    |
| procedures "                                                                                                                                                                    |                    |
| G 0172 484.30(a)                                                                                                                                                                |                    |
| DUTIES OF THE REGISTERED NURSE                                                                                                                                                  |                    |
| Bldg. 00 The registered nurse regularly re-evaluates the patients nursing needs.                                                                                                |                    |
|                                                                                                                                                                                 | 08/25/2017         |

| STATEMEN  | T OF DEFICIENCIES                                         | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | ULTIPLE CO | ONSTRUCTION                                                         | (X3) DATE S | SURVEY     |
|-----------|-----------------------------------------------------------|------------------------------|--------|------------|---------------------------------------------------------------------|-------------|------------|
| AND PLAN  | OF CORRECTION                                             | IDENTIFICATION NUMBER:       | A. BU  | JILDING    | 00                                                                  | COMPL       | ETED       |
|           |                                                           | 15K064                       | B. W   | NG         |                                                                     | 06/05/      | 2017       |
|           |                                                           |                              |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                      |             |            |
| NAME OF F | PROVIDER OR SUPPLIEF                                      | t                            |        |            | 82ND ST STE 216                                                     |             |            |
| AT HOM    | E HEALTH SERVIC                                           | SES II C                     |        |            | APOLIS, IN 46250                                                    |             |            |
| ATTIONI   | - HEALITI SERVIC                                          |                              |        | INDIAN     | AFOLIS, IN 40250                                                    |             |            |
| (X4) ID   |                                                           | TATEMENT OF DEFICIENCIES     |        | ID         | PROVIDER'S PLAN OF CORRECTION                                       |             | (X5)       |
| PREFIX    | ì ·                                                       | CY MUST BE PRECEDED BY FULL  |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE          | COMPLETION |
| TAG       |                                                           | LSC IDENTIFYING INFORMATION) | _      | TAG        | DEFICIENCY)                                                         |             | DATE       |
|           |                                                           | d to ensure that a           |        |            | instruct staff on proofing                                          |             |            |
|           | Registered Nurse                                          | e reassessed a patient       |        |            | documentation before submitti to ensure dates are correct. (T       |             |            |
|           | following surger                                          | y in 1 out of 1 record       |        |            | be done 8/25/17)                                                    | ٠ I         |            |
|           | reviewed of a pa                                          | tient who received           |        |            | Director of Nursing will be                                         |             |            |
|           | surgical procedure during a certification                 |                              |        |            | responsible to ensure orientati                                     | on          |            |
|           | period in a samp                                          | _                            |        |            | of newly hired staff are instruc                                    |             |            |
|           | periou in a samp                                          | 20 210. (110)                |        |            | on proofing documentation bet                                       |             |            |
|           | Findings include:  1. The clinical record for patient #6, |                              |        |            | submitting to ensure dates are                                      |             |            |
|           |                                                           |                              |        |            | correct. (To begin 8/25/17)                                         | .au         |            |
|           |                                                           |                              |        |            | Director of Nursing/designee v audit 100% of documentation          | VIII        |            |
|           |                                                           |                              |        |            | weekly to ensure the dates on                                       |             |            |
|           | 1                                                         | ncluded a plan of care for   |        |            | documentation are correct. On                                       |             |            |
|           | the certification                                         | period of 3/31/17 to         |        |            | 100% compliance is achieved,                                        |             |            |
|           | 5/29/17, with or                                          | ders for skilled nursing 3   |        |            | Director of Nursing/designee w                                      | vill        |            |
|           | times a week.                                             |                              |        |            | audit 25% of documentation                                          |             |            |
|           |                                                           |                              |        |            | monthly to monitor for                                              |             |            |
|           | A. A Comn                                                 | nunication log dated         |        |            | compliance. (To begin by 8/25/17).                                  |             |            |
|           |                                                           | ed the patient declined      |        |            | Director of Nursing/designee v                                      | vill        |            |
|           |                                                           | e visit on 7/6/17 (verified  |        |            | in-service RN's on need to                                          |             |            |
|           |                                                           | linical Services as a typo   |        |            | assess patient, before any oth                                      |             |            |
|           | *                                                         | • •                          |        |            | discipline makes visit, when th                                     | еу          |            |
|           |                                                           | 4/6/17) due to having        |        |            | have had a hospital stay or a                                       | .,          |            |
|           | surgery.                                                  |                              |        |            | surgical procedure done to see<br>plan of care needs to be adjus    |             |            |
|           |                                                           |                              |        |            | (To be done by 8/25/17)                                             | ieu.        |            |
|           | 1. A nu                                                   | rsing visit note dated       |        |            | Director of Nursing will be                                         |             |            |
|           | 4/7/17, indicated                                         | l a LPN (Licensed            |        |            | responsible to ensure orientati                                     | on          |            |
|           | Practical Nurse)                                          | conducted a visit, which     |        |            | of newly hired RN's includes                                        |             |            |
|           | failed to evidence                                        | e the surgical procedure     |        |            | training on need to assess                                          |             |            |
|           |                                                           | n 4/6/17. Employee C,        |        |            | patient, before any other                                           |             |            |
|           | _                                                         | stant Director of Clinical   |        |            | discipline makes visit, when the                                    | ey          |            |
|           |                                                           | supervisory visit on         |        |            | have had a hospital stay or a surgical procedure done to see        | ا if ا      |            |
|           |                                                           | -                            |        |            | plan of care needs to be adjus                                      |             |            |
|           | 4/21/17, Dui falle                                        | ed to assess the patient.    |        |            | (To begin by 8/25/17)                                               |             |            |
|           | D A Comm                                                  | nunication log detad         |        |            | Director of Nursing/designee v                                      |             |            |
|           |                                                           | nunication log dated         |        |            | audit 100% of documentation                                         |             |            |
|           |                                                           | I the patient declined a     |        |            | patients who have had a hospi                                       |             |            |
|           | home health aide                                          | e visit on 5/4/17, due to    | 1      |            | stay or a surgical procedure do                                     | one         |            |

| STATEMEN  | T OF DEFICIENCIES                     | X1) PROVIDER/SUPPLIER/CLIA   |       |          | NSTRUCTION                                                                             | (X3) DATE |            |
|-----------|---------------------------------------|------------------------------|-------|----------|----------------------------------------------------------------------------------------|-----------|------------|
| AND PLAN  | OF CORRECTION                         | IDENTIFICATION NUMBER:       |       | ILDING   | 00                                                                                     | COMPL     |            |
|           |                                       | 15K064                       | B. WI | NG       |                                                                                        | 06/05/    | 2017       |
| NAME OF P | DOMNED OD GUDDU ICA                   | •                            |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                         |           |            |
| NAME OF P | PROVIDER OR SUPPLIER                  |                              |       | 6525 E   | 82ND ST STE 216                                                                        |           |            |
|           | E HEALTH SERVIC                       |                              | T     |          | APOLIS, IN 46250                                                                       |           |            |
| (X4) ID   |                                       | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                          | (X5)      |            |
| PREFIX    |                                       | CY MUST BE PRECEDED BY FULL  |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE        | COMPLETION |
| TAG       |                                       | LSC IDENTIFYING INFORMATION) |       | TAG      | to monitor for compliance with                                                         |           | DATE       |
|           | having surgery.                       |                              |       |          | documentation they have beer                                                           |           |            |
|           |                                       |                              |       |          | assessed by an RN before any                                                           |           |            |
|           |                                       | rsing visit note dated       |       |          | other disciplines provide care.                                                        | ,         |            |
|           | 5/5/17, indicated                     | a LPN conducted a            |       |          | Once 100% compliance is                                                                |           |            |
|           | visit, which faile                    | ed to evidence the           |       |          | achieved 25% of documentation                                                          |           |            |
|           | surgical procedu                      | re the patient had on        |       |          | will be audited monthly for tho                                                        |           |            |
|           |                                       | ee C made a supervisory      |       |          | patients to ensure compliance (To begin by 8/25/17)                                    |           |            |
|           |                                       | but failed to assess the     |       |          | Director of Nursing will be                                                            |           |            |
|           | patient.                              |                              |       |          | responsible for monitoring the                                                         | se        |            |
|           | · · · · · · · · · · · · · · · · · · · |                              |       |          | corrective actions to ensure th                                                        |           |            |
|           | C The nevt                            | Registered Nurse             |       |          | deficiency is corrected and wil                                                        | I         |            |
|           | recertification assessment visit was  |                              |       |          | not recur.                                                                             |           |            |
|           |                                       |                              |       |          |                                                                                        |           |            |
|           |                                       | 29/17, by Employee C.        |       |          |                                                                                        |           |            |
|           |                                       | ed to conduct the initial    |       |          |                                                                                        |           |            |
|           |                                       | s the patient after the      |       |          |                                                                                        |           |            |
|           | patient had surge                     | ery.                         |       |          |                                                                                        |           |            |
|           |                                       |                              |       |          |                                                                                        |           |            |
|           |                                       | ee C was unable to           |       |          |                                                                                        |           |            |
|           | -                                     | her documentation when       |       |          |                                                                                        |           |            |
|           | asked on 6/5/17                       | at 1:30 p.m.                 |       |          |                                                                                        |           |            |
|           | 2. An undated p                       | olicy titled "Skilled        |       |          |                                                                                        |           |            |
|           | _                                     | s" C - 200, indicated "      |       |          |                                                                                        |           |            |
|           | _                                     | Nurse Regularly              |       |          |                                                                                        |           |            |
|           | reevaluates the c                     |                              |       |          |                                                                                        |           |            |
|           |                                       | necessary services "         |       |          |                                                                                        |           |            |
|           |                                       | iccessary services           |       |          |                                                                                        |           |            |
| G 0173    | 484.30(a)                             |                              |       |          |                                                                                        |           |            |
|           |                                       | REGISTERED NURSE             |       |          |                                                                                        |           |            |
| Bldg. 00  | _                                     | rse initiates the plan of    |       |          |                                                                                        |           |            |
|           | care and necessar                     | -                            |       | 0        | Discrete of Nov. 1 / 1 / 1                                                             |           |            |
|           |                                       | review and interview,        | G 01  | 173      | Director of Nursing/designee v                                                         |           | 08/25/2017 |
|           |                                       | l to ensure the plan of      |       |          | instruct nurses when patient had order for home health aide to                         | as        |            |
|           | care was updated                      |                              |       |          | indicate who is responsible to                                                         |           |            |
|           | determination of                      | duration of home health      |       |          | determine how many hours                                                               |           |            |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMEN                                   | NT OF DEFICIENCIES                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | JLTIPLE CO                     | NSTRUCTION                                                         | (X3) DATE S | SURVEY     |
|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------|--------------------------------|--------------------------------------------------------------------|-------------|------------|
| AND PLAN                                   | OF CORRECTION                                                                                                                                                                                     | IDENTIFICATION NUMBER:       | A. BU  | ILDING                         | 00                                                                 | COMPL       | ETED       |
|                                            |                                                                                                                                                                                                   | 15K064                       | B. WI  | NG                             |                                                                    | 06/05/      | 2017       |
|                                            |                                                                                                                                                                                                   |                              |        | STREET A                       | ADDRESS, CITY, STATE, ZIP CODE                                     |             |            |
| NAME OF F                                  | PROVIDER OR SUPPLIEF                                                                                                                                                                              | 8                            |        |                                | 82ND ST STE 216                                                    |             |            |
| AT HOM                                     | E HEALTH SERVIC                                                                                                                                                                                   | CESTIC                       |        |                                | APOLIS, IN 46250                                                   |             |            |
|                                            |                                                                                                                                                                                                   |                              | 1      | l                              | 711 0210, 114 10200                                                | ı           |            |
| (X4) ID                                    |                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES     |        | ID                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |             | (X5)       |
| PREFIX                                     | `                                                                                                                                                                                                 | ICY MUST BE PRECEDED BY FULL |        | PREFIX                         | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                    | ΓE          | COMPLETION |
| TAG                                        |                                                                                                                                                                                                   | LSC IDENTIFYING INFORMATION) | +      | TAG                            | patient needs when order says                                      |             | DATE       |
|                                            | _                                                                                                                                                                                                 | fic and pertinent to the     |        |                                | "up to" number of hours. Nurse                                     |             |            |
|                                            |                                                                                                                                                                                                   | 1 6 out of 7 active          |        |                                | should indicate if patient is                                      | ,,,         |            |
|                                            | records reviewed                                                                                                                                                                                  | d (#2, 3, 4, 5, 7 and 8) of  |        |                                | cognitive to make own persona                                      | al          |            |
|                                            | patients with hor                                                                                                                                                                                 | me health aides in a         |        |                                | care decisions. If not then                                        |             |            |
|                                            | sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed (#2, 3, 4, 5, 6, 7 and 8) in a sample of 10; failed to update a |                              |        |                                | indicate who determines time -                                     | _           |            |
|                                            |                                                                                                                                                                                                   |                              |        |                                | caregiver, RN, etc. (To be                                         |             |            |
|                                            |                                                                                                                                                                                                   |                              | 1      |                                | completed by 8/25/17)                                              |             |            |
|                                            |                                                                                                                                                                                                   |                              | 1      |                                | Director of Nursing will be<br>responsible to ensure orientati     | on          |            |
|                                            |                                                                                                                                                                                                   |                              |        |                                | of newly hired nurses includes                                     |             |            |
| patient's personal location of services to |                                                                                                                                                                                                   |                              |        | instructing nurses when patien |                                                                    |             |            |
|                                            |                                                                                                                                                                                                   |                              |        | has order for home health aide |                                                                    |             |            |
|                                            | be provided on the plan of care in 1 of 5                                                                                                                                                         |                              |        |                                | indicate who is responsible to                                     |             |            |
|                                            |                                                                                                                                                                                                   | lucted (#2); failed to       |        |                                | determine how many hours                                           |             |            |
|                                            |                                                                                                                                                                                                   | tion profile in 2 out of 8   |        |                                | patient needs when order says                                      |             |            |
|                                            | active records re                                                                                                                                                                                 | eviewed (#3 and 6), failed   |        |                                | "up to" number of hours. Nurse should indicate if patient is       | es          |            |
|                                            | to include g-tube                                                                                                                                                                                 | e site care, the amount      |        |                                | cognitive to make own persona                                      | al          |            |
|                                            | and frequency of                                                                                                                                                                                  | f water flushes, the name,   |        |                                | care decisions. If not then                                        | "           |            |
|                                            | amount, and free                                                                                                                                                                                  | quency of tube feedings,     |        |                                | indicate who determines time -                                     | _           |            |
|                                            |                                                                                                                                                                                                   | on the use of the Trilogy    |        |                                | caregiver, RN, etc. (To begin t                                    | ру          |            |
|                                            |                                                                                                                                                                                                   | machine for oxygen           |        |                                | 8/25/17)                                                           |             |            |
|                                            |                                                                                                                                                                                                   | record reviewed of a         |        |                                | Director of Nursing/designee v                                     |             |            |
|                                            |                                                                                                                                                                                                   |                              |        |                                | audit, weekly, 100% of Plans of Care to monitor for compliance     |             |            |
|                                            |                                                                                                                                                                                                   | be and a vent / bypap        |        |                                | with indicating who is responsi                                    |             |            |
|                                            | ` , , ,                                                                                                                                                                                           | nd failed to include other   |        |                                | to determine how many hours                                        | .5.10       |            |
|                                            | 1                                                                                                                                                                                                 | es assisting with the        |        |                                | patient needs when order says                                      | 3           |            |
|                                            | -                                                                                                                                                                                                 | 2 out of 4 active records    |        |                                | "up to" number of hours. Nurse                                     | es          |            |
|                                            | of patients with                                                                                                                                                                                  | more than one service in     |        |                                | should indicate if patient is                                      |             |            |
|                                            | a sample of 10.                                                                                                                                                                                   | (# 6 and 7)                  |        |                                | cognitive to make own persona                                      | al          |            |
|                                            |                                                                                                                                                                                                   |                              |        |                                | care decisions. If not then indicate who determines time -         |             |            |
|                                            | Findings include                                                                                                                                                                                  | 2.                           |        |                                | caregiver, RN, etc. Once 100%                                      |             |            |
|                                            |                                                                                                                                                                                                   |                              |        |                                | compliance is achieved, Direct                                     |             |            |
|                                            | 1 The clinical r                                                                                                                                                                                  | record for patient #2,       |        |                                | of Nursing/designee will audit                                     |             |            |
|                                            |                                                                                                                                                                                                   | re) 3/6/12, included a       |        |                                | 25% of Plans of Care monthly                                       |             |            |
|                                            | ,                                                                                                                                                                                                 | the certification period of  |        |                                | monitor for compliance. (To be                                     | egin        |            |
|                                            |                                                                                                                                                                                                   | *                            |        |                                | by 8/25/17)                                                        | .:          |            |
|                                            | 4/9/17 to 6/7/17.                                                                                                                                                                                 |                              |        |                                | Director of Nursing/designee v                                     |             |            |
|                                            |                                                                                                                                                                                                   |                              |        |                                | instruct nurses to indicate on F                                   | ridii       |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 68 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION   |       |          | (X3) DATE SURVEY                                                                      |        |            |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------|----------|---------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                             | IDENTIFICATION NUMBER:       | A. BU | JILDING  | 00                                                                                    | COMPL  | ETED       |
|                                                      |                                                                                                                                                           | 15K064                       | B. W  | ING      |                                                                                       | 06/05/ | 2017       |
|                                                      |                                                                                                                                                           |                              |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                        |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIER                                                                                                                                      | 2                            |       |          | 82ND ST STE 216                                                                       |        |            |
| AT HOM                                               | E HEALTH SERVIC                                                                                                                                           | CESTIC                       |       |          | APOLIS, IN 46250                                                                      |        |            |
|                                                      |                                                                                                                                                           |                              | 1     |          | , a dele, at 16266                                                                    |        |            |
| (X4) ID                                              |                                                                                                                                                           | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                         |        | (X5)       |
| PREFIX                                               | `                                                                                                                                                         | CY MUST BE PRECEDED BY FULL  |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΓE     | COMPLETION |
| TAG                                                  |                                                                                                                                                           | LSC IDENTIFYING INFORMATION) |       | TAG      | ,                                                                                     | -4     | DATE       |
|                                                      | _                                                                                                                                                         | of care indicated home       |       |          | of Care the following: the corre<br>address, status of others living                  |        |            |
|                                                      | aide services up                                                                                                                                          | to 8 hours per day, 5        |       |          | the home, what tasks are to be                                                        |        |            |
|                                                      | days per week. T                                                                                                                                          | The durations of hours       |       |          | provided by staff and                                                                 | •      |            |
|                                                      | failed to be patie                                                                                                                                        | ent specific and include     |       |          | when(nursing/aide). (To be                                                            |        |            |
|                                                      | the minimal hou                                                                                                                                           | rs per day for the home      |       |          | completed by 8/25/17)                                                                 |        |            |
|                                                      |                                                                                                                                                           | in the home and who          |       |          | Director of Nursing will be                                                           |        |            |
|                                                      |                                                                                                                                                           | ed the duration of hours     |       |          | responsible to ensure newly hi                                                        |        |            |
|                                                      |                                                                                                                                                           |                              |       |          | nurses are trained to indicate of                                                     |        |            |
|                                                      | in a day should the home health aide not be needed for the entire 8 hours.  B. The plan of care indicated skilled nursing to obtain oxygen saturations as |                              |       |          | Plan of Care the following: the                                                       |        |            |
|                                                      |                                                                                                                                                           |                              |       |          | correct address, status of othe living in the home, what tasks                        |        |            |
|                                                      |                                                                                                                                                           |                              |       |          | to be provided by staff and                                                           | aic    |            |
|                                                      |                                                                                                                                                           |                              |       |          | when(nursing/aide). (To be be                                                         | ain    |            |
|                                                      |                                                                                                                                                           |                              |       |          | by 8/25/17)                                                                           | 5      |            |
|                                                      | needed. The pla                                                                                                                                           | n of care failed to          |       |          | Director of Nursing/designee w                                                        | vill   |            |
|                                                      | indicate when to                                                                                                                                          |                              |       |          | audit, weekly, 100% of Plans of                                                       |        |            |
|                                                      | saturations.                                                                                                                                              | 3.5                          |       |          | Care to monitor for compliance                                                        |        |            |
|                                                      | Saturations.                                                                                                                                              |                              |       |          | indicating the Plan of Care has                                                       |        |            |
|                                                      | C A homo                                                                                                                                                  | visit on 6/1/17 at 9:15      |       |          | the following: the correct address status of others living in the                     | ess,   |            |
|                                                      |                                                                                                                                                           |                              |       |          | home, what tasks are to be                                                            |        |            |
|                                                      |                                                                                                                                                           | cted at the patient's        |       |          | provided by staff and                                                                 |        |            |
|                                                      | _                                                                                                                                                         | where the patient had        |       |          | when(nursing/aide). Once 100                                                          | %      |            |
|                                                      | been residing. T                                                                                                                                          | The new address of           |       |          | compliance is achieved, Direct                                                        | tor    |            |
|                                                      | residence was no                                                                                                                                          | ot listed on the plan of     |       |          | of Nursing/designee will audit                                                        |        |            |
|                                                      | care. The plan of                                                                                                                                         | of care included a former    |       |          | 25% of Plans of Care monthly                                                          |        |            |
|                                                      | _                                                                                                                                                         | ervices were initially       |       |          | monitor for compliance. (To be                                                        | egin   |            |
|                                                      |                                                                                                                                                           | ng this time, the home       |       |          | by 8/25/17) Director of Nursing/designee w                                            | vill   |            |
|                                                      |                                                                                                                                                           | ated the patient use to      |       |          | instruct nurses that a verbal or                                                      |        |            |
|                                                      |                                                                                                                                                           | but moved in with the        |       |          | is needed from MD to make ex                                                          |        |            |
|                                                      |                                                                                                                                                           |                              |       |          | visits that fall outside the order                                                    | ed     |            |
|                                                      | _                                                                                                                                                         | d been residing with the     |       |          | visit frequency for that disciplir                                                    | ne     |            |
|                                                      | -                                                                                                                                                         | ng time and could not        |       |          | of the Plan of Care and the nu                                                        |        |            |
|                                                      |                                                                                                                                                           | the patient had moved.       |       |          | must complete documentation                                                           |        |            |
|                                                      | The home health                                                                                                                                           | aide also indicated that     |       |          | all visits made. (To be complet                                                       | ted    |            |
|                                                      | the daughter was                                                                                                                                          | s disabled.                  |       |          | by 8/25/17)                                                                           |        |            |
|                                                      |                                                                                                                                                           |                              |       |          | Director of Nursing will be responsible to ensure orientati                           | on     |            |
|                                                      | 2 The clinical r                                                                                                                                          | ecord for patient #3,        |       |          | of newly hired nurses includes                                                        |        |            |
|                                                      |                                                                                                                                                           | ncluded a plan of care       |       |          | training on needing a verbal or                                                       |        |            |
|                                                      | 50C 11/26/10, L                                                                                                                                           | nciuutu a pian oi cale       |       |          |                                                                                       |        |            |

| STATEMEN  | NT OF DEFICIENCIES                       | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | ULTIPLE CO | ONSTRUCTION                                                            | (X3) DATE S  | SURVEY     |
|-----------|------------------------------------------|------------------------------|--------|------------|------------------------------------------------------------------------|--------------|------------|
| AND PLAN  | OF CORRECTION                            | IDENTIFICATION NUMBER:       | A. BU  | JILDING    | 00                                                                     | COMPL        | ETED       |
|           |                                          | 15K064                       | B. W   | ING        |                                                                        | 06/05/       | 2017       |
|           |                                          |                              |        | STREET     | ADDRESS, CITY, STATE, ZIP CODE                                         |              |            |
| NAME OF I | PROVIDER OR SUPPLIEF                     | ₹                            |        |            | 82ND ST STE 216                                                        |              |            |
| AT HOM    | E HEALTH SERVIC                          | CES LLC                      |        |            | IAPOLIS, IN 46250                                                      |              |            |
| (X4) ID   | SUMMARY S                                | TATEMENT OF DEFICIENCIES     |        | ID         | PROVIDER'S PLAN OF CORRECTION                                          |              | (X5)       |
| PREFIX    |                                          | ICY MUST BE PRECEDED BY FULL |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE          | COMPLETION |
| TAG       |                                          | LSC IDENTIFYING INFORMATION) |        | TAG        | DEFICIENCY)                                                            |              | DATE       |
|           | with orders for s                        | killed nursing every 14      |        |            | from MD to make extra visits                                           | that         |            |
|           | days for medicar                         | tion set up, oxygen          |        |            | fall outside the ordered visit frequency for that discipline or        | f the        |            |
|           | saturations as ne                        | eded and home health         |        |            | Plan of Care and nurse must                                            | i uic        |            |
|           | aide services up                         | to 8 hours per day, 7        |        |            | complete documentation for a                                           | II I         |            |
|           | days a week.                             |                              |        |            | visits made. (To begin by 8/25                                         |              |            |
|           |                                          |                              |        |            | Director of Nursing/designee                                           |              |            |
|           | Δ On 5/31                                | /17 at 3:00 p.m.,            |        |            | track all nursing visits for a mo                                      |              |            |
|           |                                          | e Interim Assistant          |        |            | to monitor for compliance with                                         | ۱            |            |
|           |                                          | ical Services, indicated     |        |            | following ordered frequency and if extra visits a                      | _            |            |
|           |                                          | ,                            |        |            | noted there is a verbal order f                                        |              |            |
|           |                                          | extra visits to the          |        |            | that visit and that nurse has                                          |              |            |
|           | patient's home to fix the medication box |                              |        |            | completed documentation for                                            | all          |            |
|           | due to medications not being refilled    |                              |        |            | visits. Once 100% compliance                                           |              |            |
|           | before her visit.                        |                              |        |            | achieved, Director of Nursing                                          |              |            |
|           |                                          |                              |        |            | track 25% of patients monthly                                          |              |            |
|           | B. On 5/31/                              | /17 at 4:10 p.m.,            |        |            | monitor for compliance. (To be by 8/25/17)                             | egin         |            |
|           | Employee C ind                           | icated she was going to      |        |            | Director of Nursing will instruct                                      | <sub>t</sub> |            |
|           |                                          | 's home that evening and     |        |            | nurses on including reason fo                                          |              |            |
|           |                                          | atient had his / her         |        |            | doing pulse oximetry, if there                                         |              |            |
|           | -                                        | our home visit on 6/1/17.    |        |            | an order on Plan of Care to do                                         | )            |            |
|           | incarcation for c                        | var nome visit on o/ 1/ 1/.  |        |            | one. (To be done by 8/25/17)                                           |              |            |
|           | C On 6/2/1                               | 7 at 4:45 n m Employee       |        |            | Director of Nursing will be responsible to ensure orientat             | ion          |            |
|           |                                          | 7 at 4:45 p.m., Employee     |        |            | of newly hired nurses includes                                         |              |            |
|           |                                          | did not obtain orders nor    |        |            | training on including reason for                                       |              |            |
|           | aid she complete                         | e nursing visit notes.       |        |            | doing pulse oximetry, if there                                         | is           |            |
|           |                                          |                              |        |            | an order on Plan of Care to do                                         | o            |            |
|           |                                          | of the home health aide      |        |            | one. (To begin by 8/25/17)                                             |              |            |
|           | visit notes dated                        | 03/29, 4/4, 4/9, 4/21,       |        |            | Director of Nursing will in-serving nurses on coordinating care w      |              |            |
|           | 4/29, 5/5, 5/8, 5/                       | 18, and 5/23/17, the         |        |            | all medical agencies involved                                          |              |            |
|           | home health aid                          | e provided services          |        |            | patient. Training will include                                         | *******      |            |
|           | approximately fi                         | rom 3 hours to 7 hours.      |        |            | documenting name of agency                                             | ,            |            |
|           | ``                                       |                              |        |            | name/title of person spoke wit                                         | th,          |            |
|           | The plan of care                         | failed to be updated to      |        |            | payer, discipline(s), frequency                                        |              |            |
|           | _                                        | sits for skilled nursing in  |        |            | duration and tasks to be provi                                         | ded.         |            |
|           |                                          | •                            |        |            | (To be done by 8/25/17)                                                |              |            |
|           | the management                           | -                            |        |            | Director of Nursing will be responsible to ensure orientat             | ion          |            |
|           | medications in between scheduled visits, |                              |        |            | responsible to ensure oriental                                         | 1011         |            |

| STATEMEN  | NT OF DEFICIENCIES                                                                                                                                              | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M   | ULTIPLE CO | NSTRUCTION                                                                             | (X3) DATE S | SURVEY     |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------|------------|----------------------------------------------------------------------------------------|-------------|------------|
| AND PLAN  | OF CORRECTION                                                                                                                                                   | IDENTIFICATION NUMBER:       | A. BU    | JILDING    | 00                                                                                     | COMPL       | ETED       |
|           |                                                                                                                                                                 | 15K064                       | B. W     | ING        |                                                                                        | 06/05/      | 2017       |
|           |                                                                                                                                                                 |                              | <u> </u> | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                                         |             |            |
| NAME OF F | PROVIDER OR SUPPLIEF                                                                                                                                            | 8                            |          |            | 82ND ST STE 216                                                                        |             |            |
|           | E HEALTH SERVIC                                                                                                                                                 |                              |          |            | APOLIS, IN 46250                                                                       |             |            |
| (X4) ID   |                                                                                                                                                                 | TATEMENT OF DEFICIENCIES     |          | ID         | PROVIDER'S PLAN OF CORRECTION                                                          |             | (X5)       |
| PREFIX    | `                                                                                                                                                               | ICY MUST BE PRECEDED BY FULL |          | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE          | COMPLETION |
| TAG       |                                                                                                                                                                 | LSC IDENTIFYING INFORMATION) |          | TAG        |                                                                                        |             | DATE       |
|           |                                                                                                                                                                 | e health aide hours failed   |          |            | of newly hired nurses includes<br>training on coordinating care w                      |             |            |
|           |                                                                                                                                                                 | cific to include the         |          |            | all medical agencies involved                                                          |             |            |
|           | minimal hours per day for the home<br>health aide to be in the home as well as<br>who would determined the duration of<br>hours in a day should the home health |                              |          |            | patient. Training will include                                                         |             |            |
|           |                                                                                                                                                                 |                              |          |            | documenting name of agency,                                                            |             |            |
|           |                                                                                                                                                                 |                              |          |            | name/title of person spoke with                                                        |             |            |
|           |                                                                                                                                                                 |                              |          |            | payer, discipline(s), frequency duration and tasks to be                               | ,           |            |
|           | aide not be need                                                                                                                                                | ed for the entire 8 hours    |          |            | provided. (To begin by 8/25/1)                                                         | 7)          |            |
|           | and when to obtain oxygen saturations.                                                                                                                          |                              |          |            | Director of Nursing/designee w                                                         |             |            |
|           |                                                                                                                                                                 |                              |          |            | audit 100% of admissions,                                                              |             |            |
|           | 3. The clinical r                                                                                                                                               | record for patient #4,       |          |            | resumptions and re-certifications                                                      |             |            |
|           | SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to                                                                                 |                              |          |            | to monitor for compliance of                                                           |             |            |
|           |                                                                                                                                                                 |                              |          |            | coordinating care with other medical agencies, if there are                            |             |            |
|           |                                                                                                                                                                 | ders for a LPN (licensed     |          |            | any. (To begin by 8/25/17)                                                             |             |            |
|           | · ·                                                                                                                                                             | up to 3 hours per day, 5     |          |            | Director of Nursing is responsi                                                        | ble         |            |
|           |                                                                                                                                                                 | ssist with personal care,    |          |            | for monitoring these corrective                                                        |             |            |
|           | 1 -                                                                                                                                                             | ation reminders, meal        |          |            | actions to ensure that this                                                            |             |            |
|           | preparation / set                                                                                                                                               |                              |          |            | deficiency is corrected and will not recur.                                            |             |            |
|           |                                                                                                                                                                 | -                            |          |            | not recui.                                                                             |             |            |
|           |                                                                                                                                                                 | The plan of care also        |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | skilled nurse to obtain      |          |            |                                                                                        |             |            |
|           | oxygen saturatio                                                                                                                                                | ons as needed.               |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 |                              |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | home visit on 6/1/17 at      |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | Employee E, a LPN, was       |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | inister liquid dilantin      |          |            |                                                                                        |             |            |
|           | •                                                                                                                                                               | dication), tylenol and       |          |            |                                                                                        |             |            |
|           | ibuprofen (used                                                                                                                                                 | for mild pain and / or       |          |            |                                                                                        |             |            |
|           | fever) and appro                                                                                                                                                | ximately 100 ml              |          |            |                                                                                        |             |            |
|           | (milliliters) of w                                                                                                                                              | ater flush through the       |          |            |                                                                                        |             |            |
|           | patient's gastric                                                                                                                                               | tube (g-tube) before,        |          |            |                                                                                        |             |            |
|           | during, and after medication                                                                                                                                    |                              |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | In the kitchen, a piece of   |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | ecured to a cabinet door     |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | of medications and water     |          |            |                                                                                        |             |            |
|           |                                                                                                                                                                 | es to administer. The        |          |            |                                                                                        |             |            |
|           | I mones with tilli                                                                                                                                              | es to administer. The        | 1        |            |                                                                                        |             |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 71 of 247

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                          | onstruction<br>00                                                                                     | (X3) DATE<br>COMPI<br>06/05 | LETED                      |  |  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------|--|--|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                       |                             |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | BE                          | (X5)<br>COMPLETION<br>DATE |  |  |
|                          | sometimes have administered prisometimes the classification to administer. Elementary to adminis | or to their arrival and finical staff would have imployee E indicated sheutube site care after the a bath. Employee E and issed using the Trilogy machine for oxygen  of the skilled nursing visit the following:  /27, 4/28, 5/2, 5/3, 5/4, 0, 5/11, 5/15, 5/16, 5/23, 5/24, 5/25, 5/30, 1/17, the visit notes illed nurse administered divater flushes.  /25, 5/30, 5/31, 6/1 and motes indicated the vided g-tube site care.  failed to be updated to the care, the amount and the flushes per g-tube, the indicated frequency of tube in the sube, when to obtain ins, and instruction on the yent and bypap |                                                                                     |                                                                                                       |                             |                            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 72 of 247

|           | NT OF DEFICIENCIES                      | X1) PROVIDER/SUPPLIER/CLIA                                                         | l í            |         | NSTRUCTION                                                                             | (X3) DATE       |            |
|-----------|-----------------------------------------|------------------------------------------------------------------------------------|----------------|---------|----------------------------------------------------------------------------------------|-----------------|------------|
| AND PLAN  | OF CORRECTION                           | IDENTIFICATION NUMBER:  15K064                                                     | A. BU<br>B. W. | JILDING | 00                                                                                     | COMPL<br>06/05/ |            |
|           |                                         | 13/(004                                                                            | D. "           |         |                                                                                        | 00/03/          | 2017       |
| NAME OF I | PROVIDER OR SUPPLIEF                    | 2                                                                                  |                |         | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                      |                 |            |
| AT HOM    | E HEALTH SERVIC                         | CES LLC                                                                            |                |         | APOLIS, IN 46250                                                                       |                 |            |
| (X4) ID   |                                         | TATEMENT OF DEFICIENCIES                                                           |                | ID      | PROVIDER'S PLAN OF CORRECTION                                                          |                 | (X5)       |
| PREFIX    | `                                       | ICY MUST BE PRECEDED BY FULL                                                       |                | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE              | COMPLETION |
| TAG       |                                         | LSC IDENTIFYING INFORMATION)                                                       |                | TAG     | DEFICIENC!)                                                                            |                 | DATE       |
|           |                                         | record for patient #5, neluded a plan of care for                                  |                |         |                                                                                        |                 |            |
|           | 1                                       | period of 3/19/17 to                                                               |                |         |                                                                                        |                 |            |
|           |                                         | _                                                                                  |                |         |                                                                                        |                 |            |
|           | · ·                                     | 5/19/17, with orders for home health aide services up to 6 hours per day, 5 days a |                |         |                                                                                        |                 |            |
|           | _                                       | nours per day, 3 days a                                                            |                |         |                                                                                        |                 |            |
|           | WCCK.                                   | week.                                                                              |                |         |                                                                                        |                 |            |
|           | Λ Ρονίουν                               | of the home health aide                                                            |                |         |                                                                                        |                 |            |
|           |                                         | visit notes during this certification                                              |                |         |                                                                                        |                 |            |
|           | period, the home health aide provided   |                                                                                    |                |         |                                                                                        |                 |            |
|           | services approximately from 1.25 to 3   |                                                                                    |                |         |                                                                                        |                 |            |
|           | hours. The durations of hours failed to |                                                                                    |                |         |                                                                                        |                 |            |
|           | be patient specific and include the     |                                                                                    |                |         |                                                                                        |                 |            |
|           |                                         | er day for the home                                                                |                |         |                                                                                        |                 |            |
|           | _                                       | in the home and who                                                                |                |         |                                                                                        |                 |            |
|           |                                         | ed the duration of hours                                                           |                |         |                                                                                        |                 |            |
|           |                                         | the home health aide not                                                           |                |         |                                                                                        |                 |            |
|           | be needed for the                       |                                                                                    |                |         |                                                                                        |                 |            |
|           |                                         |                                                                                    |                |         |                                                                                        |                 |            |
|           | _                                       | of care indicated skilled                                                          |                |         |                                                                                        |                 |            |
|           | _                                       | n oxygen saturations as                                                            |                |         |                                                                                        |                 |            |
|           | _                                       | n of care failed to                                                                |                |         |                                                                                        |                 |            |
|           | indicate when to                        | obtain oxygen                                                                      |                |         |                                                                                        |                 |            |
|           | saturations.                            |                                                                                    |                |         |                                                                                        |                 |            |
|           | 5 The clinical r                        | record for patient #6,                                                             |                |         |                                                                                        |                 |            |
|           |                                         | ncluded a plan of care for                                                         |                |         |                                                                                        |                 |            |
|           | 1                                       | period of 3/31/17 to                                                               |                |         |                                                                                        |                 |            |
|           |                                         | ders for skilled nursing 1                                                         |                |         |                                                                                        |                 |            |
|           | · ·                                     | to 2 hours per visit, 3                                                            |                |         |                                                                                        |                 |            |
|           |                                         | for the instillation of                                                            |                |         |                                                                                        |                 |            |
|           | _                                       | gation solution via                                                                |                |         |                                                                                        |                 |            |
|           |                                         | dder every visit. The                                                              |                |         |                                                                                        |                 |            |
|           |                                         | ile evidenced Clorpactin                                                           |                |         |                                                                                        |                 |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 73 of 247

|                   | OF CORRECTION                                                                                                  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                    | ì     | ULTIPLE COI<br>JILDING | NSTRUCTION<br>00                                                                                        | (X3) DATE (<br>COMPL |                    |
|-------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|------------------------|---------------------------------------------------------------------------------------------------------|----------------------|--------------------|
|                   |                                                                                                                | 15K064                                                                                                                                                                                               | B. WI |                        | <u>00</u>                                                                                               | 06/05/               |                    |
|                   | PROVIDER OR SUPPLIER                                                                                           |                                                                                                                                                                                                      |       | 6525 E 8               | DDRESS, CITY, STATE, ZIP CODE<br>32ND ST STE 216<br>APOLIS, IN 46250                                    | <u> </u>             |                    |
| (X4) ID<br>PREFIX | SUMMARY S                                                                                                      | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL                                                                                                                                                 |       | ID<br>PREFIX           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                   | (X5)<br>COMPLETION |
| TAG               |                                                                                                                | ed every Monday,                                                                                                                                                                                     |       | TAG                    | DEFICIENCY)                                                                                             |                      | DATE               |
|                   | flush and order f                                                                                              | Friday via urostomy for skilled nursing to sturations as needed.                                                                                                                                     |       |                        |                                                                                                         |                      |                    |
|                   | notes on 3/31, 4/4/14, 4/12, 4/19, 5/1, 5/3, 5/5, 5/8 5/19, 5/22, 5/24, visit notes failed instillation of the | of the skilled nursing visit 3, 4/5, 4/7, 4/10, 4/12, 4/21, 4/24, 4/26, 4/28, 5/10, 5/12, 5/15, 5/17, 5/26, and 5/29/17, the to evidence that the emedication / irrigation eter into the bladder had |       |                        |                                                                                                         |                      |                    |
|                   | was interviewed indicated the pat instillation into t discontinued. The Services provide order dated 3/2/1     | he bladder had been<br>ne Director of Clinical<br>d a physician's script /                                                                                                                           |       |                        |                                                                                                         |                      |                    |
|                   |                                                                                                                | ng a home visit on 6/2/17 patient was observed to ome.                                                                                                                                               |       |                        |                                                                                                         |                      |                    |
|                   | exclude the Clor<br>instillation / irrig<br>when to obtain of<br>failed to include                             | failed to be updated to pactin medication sation, failed to indicate xygen saturations and that the patient resided vices within a group                                                             |       |                        |                                                                                                         |                      |                    |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 74 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                    | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                       | onstruction<br>00   | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                         |                      |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | PROVIDER OR SUPPLIEF                                                                                                                               |                                                                                                                                                                                                                                                  | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>8 82ND ST STE 216<br>NAPOLIS, IN 46250                                      |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                     | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
|                                                                                                            | home.                                                                                                                                              |                                                                                                                                                                                                                                                  |                     |                                                                                                               |                      |
|                                                                                                            | SOC 12/31/16, i<br>the certification<br>6/7/17, with order                                                                                         | ecord for patient #7,<br>ncluded a plan of care for<br>period of 4/9/17 to<br>ers for home health aide<br>hours per day, 7 days a                                                                                                                |                     |                                                                                                               |                      |
|                                                                                                            | visit notes during period, the home services approxing hours. The durate be patient specific minimal hours purchastly aide to be would determined. | of the home health aide g this certification health aide provided mately from 3.5 to 6 tions of hours failed to fic and include the er day for the home in the home and who hed the duration of hours he home health aide not he entire 6 hours. |                     |                                                                                                               |                      |
|                                                                                                            | nursing to obtain                                                                                                                                  | of care indicated skilled<br>n oxygen saturations as<br>n of care failed to<br>obtain oxygen                                                                                                                                                     |                     |                                                                                                               |                      |
|                                                                                                            | the "Professiona<br>section indicated<br>receiving home Medicare agency                                                                            | of a recertification assessment dated 4/7/17, I Services" narrative I the patient was health services with a y for wound treatments. failed to evidence that                                                                                     |                     |                                                                                                               |                      |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 75 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CO A. BUILDING B. WING                                                                                               | 00                  | CON                                                                                                      | TE SURVEY<br>MPLETED<br>05/2017 |                            |
|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------|
|                                                                                                             | PROVIDER OR SUPPLIEI                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                    | 6525 E              | ADDRESS, CITY, STATE, ZIP COD<br>82ND ST STE 216<br>APOLIS, IN 46250                                     | E                               |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                             | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | LD BE                           | (X5)<br>COMPLETION<br>DATE |
|                                                                                                             | the patient's wor<br>by a Medicare a                                                                                                                                                                                                                                                                                                                                                                                       | ands were being managed gency.                                                                                                     |                     |                                                                                                          |                                 |                            |
|                                                                                                             | SOC 8/3/16, inc<br>the certification<br>5/29/17, with or                                                                                                                                                                                                                                                                                                                                                                   | record for patient #8,<br>luded a plan of care for<br>period of 3/31/17 to<br>ders for home health aide<br>hours per day, 7 days a |                     |                                                                                                          |                                 |                            |
|                                                                                                             | A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.50 to 8 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. |                                                                                                                                    |                     |                                                                                                          |                                 |                            |
|                                                                                                             | nursing to obtain                                                                                                                                                                                                                                                                                                                                                                                                          | n of care indicated skilled<br>in oxygen saturations as<br>an of care failed to<br>obtain oxygen                                   |                     |                                                                                                          |                                 |                            |
|                                                                                                             | Services and En<br>Alternate Direct<br>had no further in                                                                                                                                                                                                                                                                                                                                                                   | n relation to the above                                                                                                            |                     |                                                                                                          |                                 |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 76 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                     |                                                                                                                                                | A. BUILDING B. WING | 00                                                                                                                        | COMPLETED 06/05/2017 |  |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------|----------------------|--|
| NAME OF F                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                      |                                                                                                                                                |                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                         |                      |  |
| AT HOM                   | E HEALTH SERVIC                                                                                                                                                                                                                                                                           | ES LLC                                                                                                                                         |                     | IAPOLIS, IN 46250                                                                                                         |                      |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                            | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                              | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)     | (X5) COMPLETION DATE |  |
|                          | further informati<br>the exit conferent<br>10. An undated<br>Care" C - 580, in<br>Communication<br>is required in the<br>admission, recer<br>change in the plat<br>Plan of Care is b<br>assessment and it<br>the client / famil<br>member The It<br>completed in ful-<br>frequency, and d | nd Employee B, had no<br>on or documentation by<br>ace on 6/5/17 at 3:50 p.m.<br>policy titled "Plan of                                        |                     |                                                                                                                           |                      |  |
| G 0180<br>Bldg. 00       | procedures "  11. An undated Nursing Services The Registered Nursing Services The Registered Nursel Nursel Nursel Nursel The licensed practionical and progressed on record the agency failed                                                                                             | policy titled "Skilled s" C - 200, indicated " Nurse Regularly lients needs, and necessary services "  LICENSED PRACTICAL tical nurse prepares | G 0180              | Director of Nursing will in-ser<br>nurses on requirement to folk<br>Plan of Care which includes t<br>nurse is to provide. | DW CONTENT           |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 77 of 247

| STATEMEN      | T OF DEFICIENCIES                          | X1) PROVIDER/SUPPLIER/CLIA                                  | (X2) M | ULTIPLE CC    | ONSTRUCTION                                                        | (X3) DATE SURVEY |
|---------------|--------------------------------------------|-------------------------------------------------------------|--------|---------------|--------------------------------------------------------------------|------------------|
| AND PLAN      | OF CORRECTION                              | IDENTIFICATION NUMBER:                                      | A. BU  | JILDING       | 00                                                                 | COMPLETED        |
|               |                                            | 15K064                                                      | B. W   | ING           |                                                                    | 06/05/2017       |
|               |                                            |                                                             |        | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                     |                  |
| NAME OF I     | PROVIDER OR SUPPLIEF                       | 8                                                           |        |               | 82ND ST STE 216                                                    |                  |
| AT HOM        | E HEALTH SERVIC                            | CESTIC                                                      |        |               | APOLIS, IN 46250                                                   |                  |
|               |                                            |                                                             |        |               | , a G2.6, at 16266                                                 | T                |
| (X4) ID       |                                            | TATEMENT OF DEFICIENCIES                                    |        | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | (X5)             |
| PREFIX<br>TAG | `                                          | ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION) |        | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)                    | COMPLETION DATE  |
| IAU           |                                            | ,                                                           |        | IAU           | Care documented must follow                                        | DATE             |
|               | 1 ^                                        | ny care and bowel                                           |        |               | orders on Plan of Care. Nurse                                      | s to             |
|               |                                            | 4 active records reviewed                                   |        |               | document how patient tolerate                                      |                  |
|               | of patients with skillned nursing in a     |                                                             |        |               | the procedure being done. (To                                      |                  |
|               | sample of 10. (#                           | <del>\$</del> 6)                                            |        |               | completed by 8/25/17)                                              |                  |
|               |                                            |                                                             |        |               |                                                                    |                  |
|               | Findings include                           | <del>:</del>                                                |        |               | Director of Nursing will be                                        |                  |
|               |                                            |                                                             |        |               | responsible to ensure orientati<br>of newly hired nurses includes  |                  |
|               | 1. The clinical r                          | record for patient #6,                                      |        |               | training on requirement to follo                                   |                  |
|               |                                            | ncluded a plan of care for                                  |        |               | Plan of Care. Care documente                                       |                  |
|               | the certification period of 3/31/17 to     |                                                             |        |               | must follow orders on Plan of                                      |                  |
|               | 5/29/17, with orders for skilled nursing 1 |                                                             |        |               | Care. Nurses to document how                                       |                  |
|               | visit per day, up to 2 hours per visit, 3  |                                                             |        |               | patient tolerated the procedure                                    |                  |
|               | times per week to remove and apply a       |                                                             |        |               | being done. (To begin by 8/25 Director of Nursing/designee v       |                  |
|               | ^                                          | * * *                                                       |        |               | audit 100% of nursing                                              | VIII             |
|               |                                            | one day per week and for                                    |        |               | documentation weekly, until                                        |                  |
|               |                                            | f medication / irrigation                                   |        |               | 100% compliance is achieved                                        | to               |
|               |                                            | eter into bladder every                                     |        |               | monitor compliance with follow                                     |                  |
|               |                                            | cation profile evidenced                                    |        |               | MD ordered plan of care and t                                      | hat              |
|               | Clorpactin to be                           | administered every                                          |        |               | care provided follows the MD ordered Plan of Care and that         |                  |
|               | Monday, Wedne                              | esday, and Friday via                                       |        |               | nurses document how patient                                        |                  |
|               | urostomy flush a                           | and order for skilled                                       |        |               | tolerated the procedure being                                      |                  |
|               | nursing to obtain                          | n oxygen saturations as                                     |        |               | done. Once 100% compliance                                         | is               |
|               | needed.                                    |                                                             |        |               | achieved, Director of                                              |                  |
|               |                                            |                                                             |        |               | Nursing/designee will audit 25                                     |                  |
|               | A Review                                   | of the skilled nursing visit                                |        |               | of nursing documentation mor<br>to monitor for continued           | tnly             |
|               |                                            | /3, 4/5, 4/7, 4/10, 4/12,                                   |        |               | compliance. (To begin by                                           |                  |
|               |                                            | 4/24, 4/26, 4/28, 5/1,                                      |        |               | 8/25/17)                                                           |                  |
|               |                                            |                                                             |        |               | Director of Nursing will be                                        |                  |
|               |                                            | 0, 5/12, 5/15, 5/17, 5/19, and 5/20/17, foiled to           |        |               | responsible for monitoring the                                     |                  |
|               |                                            | and 5/29/17, failed to                                      |        |               | corrective changes to ensure t                                     |                  |
|               |                                            | e patient's urostomy                                        |        |               | deficiency is corrected and do not recur.                          | es               |
|               | wafer had been o                           | changed weekly.                                             |        |               | not recur.                                                         |                  |
|               | B. Review                                  | of the skilled nursing visit                                |        |               |                                                                    |                  |
|               | notes on 3/31, 4/                          | /3, 4/5, 4/7, 4/10, 4/14,                                   |        |               |                                                                    |                  |
|               | · ·                                        | 4/28 5/1 5/3 5/5 5/8                                        |        |               |                                                                    |                  |

|           | T OF DEFICIENCIES                           | X1) PROVIDER/SUPPLIER/CLIA          | ľ    |         | NSTRUCTION                                                                             | (X3) DATE SURVEY |   |
|-----------|---------------------------------------------|-------------------------------------|------|---------|----------------------------------------------------------------------------------------|------------------|---|
| AND PLAN  | OF CORRECTION                               | IDENTIFICATION NUMBER:              | 1    | JILDING | 00                                                                                     | COMPLETED        |   |
|           |                                             | 15K064                              | B. W | ING     |                                                                                        | 06/05/2017       |   |
| NAME OF F | PROVIDER OR SUPPLIER                        |                                     |      |         | ADDRESS, CITY, STATE, ZIP CODE                                                         |                  |   |
|           |                                             |                                     |      |         | 82ND ST STE 216                                                                        |                  |   |
| AT HOM    | E HEALTH SERVIC                             | SES LLC                             |      | INDIAN  | APOLIS, IN 46250                                                                       |                  |   |
| (X4) ID   |                                             | TATEMENT OF DEFICIENCIES            |      | ID      | PROVIDER'S PLAN OF CORRECTION                                                          | (X5)             |   |
| PREFIX    | ,                                           | CY MUST BE PRECEDED BY FULL         |      | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) |                  | Ν |
| TAG       |                                             | LSC IDENTIFYING INFORMATION)        |      | TAG     | DEFICIENC!)                                                                            | DATE             |   |
|           | l ' ' '                                     | 5/17, 5/19, 5/22, 5/24,             |      |         |                                                                                        |                  |   |
|           | 5/26, and 5/29/1                            |                                     |      |         |                                                                                        |                  |   |
|           |                                             | Fr foley catheter had been          |      |         |                                                                                        |                  |   |
|           | inserted with urine return. The notes       |                                     |      |         |                                                                                        |                  |   |
|           |                                             | failed to include where and why the |      |         |                                                                                        |                  |   |
|           | double lumen foley catheter insertion.      |                                     |      |         |                                                                                        |                  |   |
|           | C Review of the skilled nursing             |                                     |      |         |                                                                                        |                  |   |
|           |                                             | C. Review of the skilled nursing    |      |         |                                                                                        |                  |   |
|           | visit notes on 3/31, 4/3, 4/5, 4/10, 4/14,  |                                     |      |         |                                                                                        |                  |   |
|           | 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, |                                     |      |         |                                                                                        |                  |   |
|           | 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24,   |                                     |      |         |                                                                                        |                  |   |
|           | 5/26, and 5/29/17, failed to evidence that  |                                     |      |         |                                                                                        |                  |   |
|           |                                             | rel program had been                |      |         |                                                                                        |                  |   |
|           |                                             | utcome of the bowel                 |      |         |                                                                                        |                  |   |
|           | program, and the                            | e patient's tolerance of            |      |         |                                                                                        |                  |   |
|           | the procedures.                             |                                     |      |         |                                                                                        |                  |   |
|           | D The Dire                                  | ector of Clinical Services          |      |         |                                                                                        |                  |   |
|           |                                             | on 06/05/17 at 1:30 and             |      |         |                                                                                        |                  |   |
|           | indicated the pat                           |                                     |      |         |                                                                                        |                  |   |
|           |                                             | he bladder had been                 |      |         |                                                                                        |                  |   |
|           |                                             | he Director of Clinical             |      |         |                                                                                        |                  |   |
|           |                                             | ed a physician's script /           |      |         |                                                                                        |                  |   |
|           | order dated 3/2/1                           |                                     |      |         |                                                                                        |                  |   |
|           |                                             | Clorpactin instillation.            |      |         |                                                                                        |                  |   |
|           |                                             | orphotin monnation.                 |      |         |                                                                                        |                  |   |
|           | E. The Alte                                 | rnate Administrator and             |      |         |                                                                                        |                  |   |
|           | the Director of C                           | Clinical Services had not           |      |         |                                                                                        |                  |   |
|           | further informati                           | on or documentation by              |      |         |                                                                                        |                  |   |
|           |                                             | ace on 06/05/17 at 3:50             |      |         |                                                                                        |                  |   |
|           | p.m.                                        |                                     |      |         |                                                                                        |                  |   |
|           |                                             |                                     |      |         |                                                                                        |                  |   |
|           | _                                           | olicy titled "Skilled               |      |         |                                                                                        |                  |   |
|           | Nursing Services                            | s" C - 200, indicated "             |      |         |                                                                                        |                  |   |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 79 of 247

| STATEMEN  | T OF DEFICIENCIES                    | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | ULTIPLE CO | ONSTRUCTION                                                        | (X3) DATE | SURVEY     |
|-----------|--------------------------------------|------------------------------|--------|------------|--------------------------------------------------------------------|-----------|------------|
| AND PLAN  | OF CORRECTION                        | IDENTIFICATION NUMBER:       | A. BU  | JILDING    | 00                                                                 | COMPL     | ETED       |
|           |                                      | 15K064                       | B. W   | NG         |                                                                    | 06/05/    | 2017       |
|           |                                      |                              |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                     |           |            |
| NAME OF P | ROVIDER OR SUPPLIER                  |                              |        |            | 82ND ST STE 216                                                    |           |            |
| AT HOMI   | E HEALTH SERVIC                      | ES LLC                       |        |            | APOLIS, IN 46250                                                   |           |            |
| (X4) ID   | SUMMARY S                            | FATEMENT OF DEFICIENCIES     |        | ID         | <u>,                                      </u>                     |           | (X5)       |
| PREFIX    |                                      | CY MUST BE PRECEDED BY FULL  |        | PREFIX     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | _         | COMPLETION |
| TAG       | REGULATORY OR                        | LSC IDENTIFYING INFORMATION) |        | TAG        | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                      | IE        | DATE       |
|           | The Licensed Pra                     | actical Nurse Assists        |        |            |                                                                    |           |            |
|           | the regisered nur                    | se to complete the           |        |            |                                                                    |           |            |
|           | physician plan of                    | f care for skilled services  |        |            |                                                                    |           |            |
|           | Prepares clinical and progress notes |                              |        |            |                                                                    |           |            |
|           |                                      |                              |        |            |                                                                    |           |            |
|           |                                      |                              |        |            |                                                                    |           |            |
| G 0181    | 484.30(b)                            |                              |        |            |                                                                    |           |            |
|           |                                      | LICENSED PRACTICAL           |        |            |                                                                    |           |            |
| Bldg. 00  | NURSE                                | tical nurse assists the      |        |            |                                                                    |           |            |
|           |                                      | stered nurse in performing   |        |            |                                                                    |           |            |
|           | specialized proced                   |                              |        |            |                                                                    |           |            |
|           | Based on record                      | review and interview,        | G 0    | 181        | Director of Nursing will in-servi                                  |           | 08/25/2017 |
|           | the agency failed                    | l to ensure the Licensed     |        |            | nurses on requirement to follow                                    | W         |            |
|           | Practical Nurse (                    | LPN) followed the plan       |        |            | Plan of Care which includes frequency and duration for             |           |            |
|           | of care in relation                  | n to frequency and           |        |            | disciplines ordered by MD and                                      |           |            |
|           | duration of patie                    | nt visits, personal care,    |        |            | was tasks nurse is to provide.                                     |           |            |
|           | and providing se                     | rvices without a             |        |            | visit is not made, nurse will                                      |           |            |
|           | physician's order                    | in 2 out of 4 active         |        |            | document reason, complete a missed visit report and notify N       | 4D        |            |
|           | records reviewed                     | of patients with skilled     |        |            | of missed visit. If patient requir                                 |           |            |
|           | nursing in a sam                     | ple of 10. (#4 and 6)        |        |            | a task that is not listed on the                                   |           |            |
|           |                                      | , ,                          |        |            | Plan of care, nurse will contact                                   |           |            |
|           | Findings include                     | :                            |        |            | MD and obtain an order for the needed task. If LPN notes ther      |           |            |
|           | C                                    |                              |        |            | is something needed that is no                                     |           |            |
|           | 1. The clinical re                   | ecord for patient #4,        |        |            | on the Plan of Care, LPN will                                      |           |            |
|           |                                      | cluded a plan of care for    |        |            | contact he RN case manager                                         | or        |            |
|           | -                                    | period of 4/24/17 to         |        |            | Director of Nursing to discuss                                     |           |            |
|           |                                      | ders for a licensed          |        |            | patient's need before MD is contacted. (To be completed by         | W.        |            |
|           | -                                    | LPN) up to 3 hours per       |        |            | 8/25/17)                                                           | y         |            |
|           | -                                    | ek to assist with personal   |        |            | Director of Nursing will be                                        |           |            |
|           |                                      | nedication reminders,        |        |            | responsible to ensure orientati                                    |           |            |
|           |                                      | / setup, and light           |        |            | of newly hired nurses includes                                     |           |            |
|           | housekeeping.                        | i / socup, and right         |        |            | training on requirement to follor Plan of Care which includes      | )W        |            |
|           | nousekeeping.                        |                              |        |            | frequency and duration for                                         |           |            |
|           | A Dumin = =                          | homo vigit on 6/1/17 of      |        |            | disciplines ordered by MD and                                      |           |            |
|           | A. During a                          | home visit on $6/1/17$ at    |        |            | was tasks nurse is to provide.                                     | lf a      |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 80 of 247

| STATEMEN  | NT OF DEFICIENCIES                        | X1) PROVIDER/SUPPLIER/CLIA      | (X2) M | ULTIPLE CO | ONSTRUCTION                                                         | (X3) DATE S | URVEY      |
|-----------|-------------------------------------------|---------------------------------|--------|------------|---------------------------------------------------------------------|-------------|------------|
| AND PLAN  | OF CORRECTION                             | IDENTIFICATION NUMBER:          | A. BU  | JILDING    | 00                                                                  | COMPLE      | ETED       |
|           |                                           | 15K064                          | B. W   | ING        |                                                                     | 06/05/2     | 2017       |
|           |                                           |                                 |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                      |             |            |
| NAME OF I | PROVIDER OR SUPPLIEF                      | 8                               |        |            | 82ND ST STE 216                                                     |             |            |
| AT HOM    | E HEALTH SERVIC                           | CES LLC                         |        |            | APOLIS, IN 46250                                                    |             |            |
| (X4) ID   |                                           | TATEMENT OF DEFICIENCIES        |        | ID         | PROVIDER'S PLAN OF CORRECTION                                       |             | (X5)       |
| PREFIX    | `                                         | ICY MUST BE PRECEDED BY FULL    |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE          | COMPLETION |
| TAG       |                                           | LSC IDENTIFYING INFORMATION)    |        | TAG        | DEFICIENCY)                                                         |             | DATE       |
|           |                                           | oyee E, LPN was                 |        |            | visit is not made, nurse will document reason, complete a           |             |            |
|           | observed to adm                           | inister liquid dilantin         |        |            | missed visit report and notify N                                    | 4D          |            |
|           | (anti-seizure me                          | dication), tylenol and          |        |            | of missed visit. If patient requir                                  |             |            |
|           | ibuprofen (used                           | for mild pain and / or          |        |            | a task that is not listed on the                                    |             |            |
|           | fever) and appro                          | fever) and approximately 100 ml |        |            | Plan of care, nurse will contac                                     | t           |            |
|           |                                           | rater flush through the         |        |            | MD and obtain an order for the                                      |             |            |
|           | ,                                         | tube (g-tube) before,           |        |            | needed task. If LPN notes the                                       |             |            |
|           | during, and after                         |                                 |        |            | is something needed that is no on the Plan of Care, LPN will        | Dt          |            |
|           | _                                         | In the kitchen, a piece of      |        |            | contact he RN case manager                                          | or          |            |
|           |                                           | ecured to a cabinet door        |        |            | Director of Nursing to discuss                                      |             |            |
|           |                                           |                                 |        |            | patient's need before MD is                                         |             |            |
|           | contained a list of medications and water |                                 |        |            | contacted. (To begin by 8/25/1                                      |             |            |
|           | flushes with times to administer.         |                                 |        |            | Director of Nursing/designee v                                      | vill        |            |
|           |                                           | icated the spouse would         |        |            | audit 100% of nursing                                               |             |            |
|           | sometimes have                            | the medications                 |        |            | documentation weekly, until 100% compliance is achieved,            | to          |            |
|           | administered pri                          | or to their arrival and         |        |            | monitor compliance with follow                                      |             |            |
|           | sometimes the c                           | linical staff would have        |        |            | frequency and duration for                                          | 9           |            |
|           | to administer. E                          | mployee E indicated she         |        |            | disciplines ordered by MD as v                                      | well        |            |
|           | would provide g                           | -tube site care after the       |        |            | MD ordered plan of care and t                                       | hat         |            |
|           | patient received                          |                                 |        |            | care provided follows the MD                                        | 200/        |            |
|           |                                           |                                 |        |            | ordered Plan of Care. Once 10 compliance is achieved, Direct        |             |            |
|           | R Review                                  | of the skilled nursing visit    |        |            | of Nursing/designee will audit                                      | 101         |            |
|           | notes indicated t                         | •                               |        |            | 25% of nursing documentation                                        | ı           |            |
|           | notes marcatea t                          | ne ionowing.                    |        |            | monthly to monitor for continue                                     | ed          |            |
|           | 1 0 1                                     | 127 4/29 5/2 5/2 5/4            |        |            | compliance. (To begin by                                            |             |            |
|           |                                           | /27, 4/28, 5/2, 5/3, 5/4,       |        |            | 8/25/17)                                                            |             |            |
|           | 1 1 1                                     | 0, 5/11, 5/15, 5/16, 5/17,      |        |            | Director of Nursing will be responsible for monitoring the          |             |            |
|           |                                           | 5/24, 5/25, 5/30, 5/31,         |        |            | corrective actions to ensure th                                     |             |            |
|           | · ·                                       | he visit notes indicated        |        |            | deficiency is corrected and wil                                     |             |            |
|           |                                           | administered tube               |        |            | not recur.                                                          |             |            |
|           | feedings.                                 |                                 |        |            |                                                                     |             |            |
|           |                                           |                                 |        |            |                                                                     |             |            |
|           | 2. On 5                                   | 5/8, 5/9, 5/10, 5/11, 5/15,     |        |            |                                                                     |             |            |
|           | 5/16, 5/24, 5/25,                         | 5/30, 5/31, 6/1 and             |        |            |                                                                     |             |            |
|           |                                           | notes indicated the             |        |            |                                                                     |             |            |
|           | •                                         | ninistered water flushes.       |        |            |                                                                     |             |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                | (X2) MULTIPLE CO A. BUILDING B. WING                                                                                                                           | ONSTRUCTION  00     | COM                                                                                                    | TE SURVEY<br>MPLETED<br>05/2017 |                            |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------|
|                                                                                                              | PROVIDER OR SUPPLIEI                                                                                                                                                           |                                                                                                                                                                | 6525 E              | ADDRESS, CITY, STATE, ZIP COI<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                  | DE .                            |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                     | (EACH DEFICIEN                                                                                                                                                                 | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | JLD BE                          | (X5)<br>COMPLETION<br>DATE |
|                                                                                                              | 6/2/17, the visit                                                                                                                                                              | 5/25, 5/30, 5/31, 6/1 and notes indicated the ovided g-tube site care.                                                                                         |                     |                                                                                                        |                                 |                            |
|                                                                                                              | and 6/4/17, the v                                                                                                                                                              | 3/4, 5/17, 5/25, 5/31, 6/1, visit notes indicated the s in the home for 4 hours a on 5/23/17.                                                                  |                     |                                                                                                        |                                 |                            |
|                                                                                                              | 5. Three (3) skilled nursing visits were made week 1 and 4 of the certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period. |                                                                                                                                                                |                     |                                                                                                        |                                 |                            |
|                                                                                                              | 5/4, 5/5, 5/8, 5/9<br>5/17, 5/18, 5/22                                                                                                                                         | 25, 4/27, 4/28, 5/2, 5/3, 9, 5/10, 5/11, 5/15, 5/16, 5/23 and 5/24/17, failed ersonal care had been                                                            |                     |                                                                                                        |                                 |                            |
|                                                                                                              | plan of care in reduration of visit                                                                                                                                            | es failed to follow the egards to frequency and s, providing personal providing services sian's order.                                                         |                     |                                                                                                        |                                 |                            |
|                                                                                                              | SOC 1/30/17, in the certification 5/29/17, with or visit per day, up                                                                                                           | record for patient #6,<br>ncluded a plan of care for<br>period of 3/31/17 to<br>ders for skilled nursing 1<br>to 2 hours per visit, 3<br>to remove and apply a |                     |                                                                                                        |                                 |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 82 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                         | ONSTRUCTION  00     | (X3) DATE<br>COMPI<br>06/05                                                                                     | LETED |                            |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------|-------|----------------------------|
|                                                                                                           | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                    | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>JAPOLIS, IN 46250                                          |       |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                  | (EACH DEFICIEN<br>REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | BE    | (X5)<br>COMPLETION<br>DATE |
|                                                                                                           | A. Review 6 3/31, 4/3, 4/5, 4/ 4/19, 4/21, 4/24, 5/8, 5/10, 5/12, 5 5/24, 5/26, and 5 failed to evidence urostomy wafer weekly. The ski follow the plan of 4. Employee B, Services and Em Alternate Direct had no further in documentation in findings on 6/2/1 5. Employee A Administrator ar on 6/5/17 at 3:50 of hours may be being included in Authorization ho there is no deline 6. An undated p Care" C - 580, in care is a dynamic the care, treatme provided The Care is based on | the Director of Clinical aployee C, the Interim or of Clinical Services, formation or a relation to the above 1.7 at 4:00 p.m.  In the Alternate and Employee B, indicated a p.m., that the overage due to waiver hours at the Medicaid Prior ours. Both indicated |                     |                                                                                                                 |       |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 83 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|           | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA           |          |              | INSTRUCTION                                                                             | (X3) DATE S     |            |
|-----------|---------------------|--------------------------------------|----------|--------------|-----------------------------------------------------------------------------------------|-----------------|------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER:  15K064       | B. WI    | ILDING<br>NG | 00                                                                                      | COMPL<br>06/05/ |            |
|           |                     | 15/004                               | B. WII   |              |                                                                                         | 06/05/          | 2017       |
| NAME OF P | ROVIDER OR SUPPLIER |                                      |          |              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                       |                 |            |
| AT HOME   | E HEALTH SERVIC     | ES LLC                               |          |              | APOLIS, IN 46250                                                                        |                 |            |
| (X4) ID   | SUMMARY ST          | TATEMENT OF DEFICIENCIES             |          | ID           | PROVIDER'S PLAN OF CORRECTION                                                           |                 | (X5)       |
| PREFIX    |                     | CY MUST BE PRECEDED BY FULL          |          | PREFIX       | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                 | COMPLETION |
| TAG       |                     | LSC IDENTIFYING INFORMATION)         |          | TAG          | DEFICIENCY)                                                                             |                 | DATE       |
|           |                     | y and health team                    |          |              |                                                                                         |                 |            |
|           |                     | Plan of Care shall be                |          |              |                                                                                         |                 |            |
|           | •                   | to include Type,                     |          |              |                                                                                         |                 |            |
|           |                     | uration of all visits /              |          |              |                                                                                         |                 |            |
|           | · ·                 | tions, treatments, and               |          |              |                                                                                         |                 |            |
|           | procedures "        |                                      |          |              |                                                                                         |                 |            |
|           | 7. An undated p     | 7. An undated policy titled "Skilled |          |              |                                                                                         |                 |            |
|           | Nursing Services    | s" C - 200, indicated "              |          |              |                                                                                         |                 |            |
|           | The Licensed Pra    | actical Nurse Assists                |          |              |                                                                                         |                 |            |
|           | the regisered nur   | se to complete the                   |          |              |                                                                                         |                 |            |
|           | physician plan of   | f care for skilled services          |          |              |                                                                                         |                 |            |
|           | Prepares clinic     | cal and progress notes               |          |              |                                                                                         |                 |            |
| "         |                     |                                      |          |              |                                                                                         |                 |            |
|           |                     |                                      |          |              |                                                                                         |                 |            |
| G 0183    | 484.30(b)           | LICENSED PRACTICAL                   |          |              |                                                                                         |                 |            |
| Bldg. 00  | NURSE               | LIGENGEDT NACTIONE                   |          |              |                                                                                         |                 |            |
| g         |                     | tical nurse assists the              |          |              |                                                                                         |                 |            |
|           |                     | appropriate self-care                |          |              |                                                                                         |                 |            |
|           | techniques.         | review and interview,                | $G_{01}$ | 83           | Director of Nursing/designee w                                                          | vill            | 08/25/2017 |
|           |                     | ctical Nurse (LPN) failed            | 001      | .03          | in-service nursing staff on                                                             | ,               | 08/23/2017 |
|           |                     | ne skilled nursing visit             |          |              | accurately documenting care                                                             |                 |            |
|           |                     | eding administered,                  |          |              | provided specifically indicating what education was done and                            |                 |            |
|           |                     | luid intake, specific the            |          |              | patient/caregiver response, if N                                                        | мD              |            |
|           |                     | was taught to the patient,           |          |              | was notified of changes or                                                              |                 |            |
|           |                     | hing, disease process                |          |              | concerns what changes if any                                                            |                 |            |
|           | teaching, reason    |                                      |          |              | were ordered, explaining tasks that were done in detail – i.e. t                        |                 |            |
|           | •                   | ell as the follow up on              |          |              | feedings to include type of                                                             | ubc             |            |
|           |                     | cated with the patient and           |          |              | solution and amount                                                                     |                 |            |
|           |                     | ation in 1 of 10 records             |          |              | administered, assessment as<br>ordered on Plan of Care. Nurs                            | 95              |            |
|           | reviewed. (#4)      |                                      |          |              | to sign documentation. (To be                                                           | ರತ              |            |
|           | 10110Wod. (#T)      |                                      |          |              | completed by 8/25/17)                                                                   |                 |            |
|           | Findings include:   |                                      |          |              | Director of Nursing is responsi                                                         | ble             |            |
|           | -                   |                                      |          |              | to ensure orientation of newly                                                          |                 |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 84 of 247

| 1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed.  The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feeding administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were ducation and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STATEMEN        | T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ONSTRUCTION | (X3) DATE SURVEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICES LLC  INDA 1D  SUMMARY STATIMENT OF DIFFICIENCIES  (SEE 1D  SERVING SERVING STATE SERVICES SERVING STATE, 2IP CODE (6525 E 82ND ST STE 2 16 INDIANAPOLIS, IN 46250  IN 16 CEACH DEFICIENCY MIST BE PRECEDED BY BULL PREFIX TAG  REGULATORY OR ISC DESTIFYING INFORMATION)  1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feeding administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings. The visit note failed to evidence the type and amount of tube feedings administered.  C. On 5/3, 5/4 and 5/5/17, the visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | AND PLAN        | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A. BU       | ILDING           | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | COMPL                           | ETED       |
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC  (N4) ID  SUMMARY STATIMENT OF DEPICIENCIES PREFIX TAG  1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the type and amount of tube feeding administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings. The visit notes failed to evidence the daministered.  C. On 5/3, 5/4 and 5/5/17, the visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. 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WI       | NG               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 06/05/                          | 2017       |
| AT HOME HEALTH SERVICES LLC  (X9) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  I. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the type and amount of tube feedings.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note indicated the interventions provided were the administration of tube feedings. The visit note indicated the interventions provided were the administration of tube feedings. The visit note sindicated the interventions provided were the administration of tube feedings. 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The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <u> </u>    | CTD FFT A        | ADDRESS CITY STATE ZIR CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |            |
| AT HOME HEALTH SERVICES LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCES (ACATI DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feedings administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note failed to evidence the type and amount of tube feedings administered.  C. On 5/3, 5/4 and 5/5/17, the visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | NAME OF P       | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |             |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |            |
| ID PREFIX   GEATI DEFICIENCY MUST BE PRECEDED BY FULL   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATO   | A.T. L. C. A.E. | - LIEAL TH OED) (10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NEO 11 O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |             |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |            |
| PREFIX TAG REQULATORY OR LSC IDENTIFYING BYPRECEDED BY FULL TAG REQULATORY OR LSC IDENTIFYING BYPORMATION)  1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feedings administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings administered.  C. On 5/3, 5/4 and 5/5/17, the visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were done in detail — i.e. tube feedings to have detail and patient/caregiver response, if MD was notified to evidence with a subministration of tube feedings. T | AT HOME         | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |             | INDIAN           | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |            |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed.  The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were teadministrered.  C. On 5/3, 5/4 and 5/5/17, the visit note sindicated the interventions provided were the administration of tube feedings. The visit note sindicated the interventions provided were the administration of tube feedings. The visit note sindicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X4) ID         | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |             | ID               | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 | (X5)       |
| 1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed.  The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feeding administration of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note sindicated the interventions provided were the administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | PREFIX          | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |             | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TE                              | COMPLETION |
| 1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the following:  A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feedings administered.  B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit note failed to evidence the type and amount of tube feedings. The visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | TAG             | REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |             | TAG              | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 | DATE       |
| patient's understanding of tube feedings, and the type and amount of tube feedings administered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | IAU             | 1. The clinical re (start of care) 4/ The skilled nursi the following:  A. On 4/27/ indicated the interest teaching on new teaching, disease administered tub note failed to evidiet, and disease and patient's und type and amount administered.  B. On 4/28, 5/23/17, the visit interventions programmed amount of tube for the company of the | ecord for patient #4 SOC 26/17, was reviewed. ing visit notes indicated /17, the visit note erventions provided were medication, diet erocess teaching and be feedings. The visit idence the medications, process that were taught derstanding as well as the cof tube feeding /17, 5/19, 5/22 and to note indicated the ovided were the fitube feedings. The visit idence the type and feedings administered. /18/4 and 5/5/17, the visit he interventions ducation and fitube feedings. The visit vidence what was reds to tube feedings, the anding of tube feedings, |             | IAU              | hired nurses includes training accurately documenting care provided specifically indicating what education was done and patient/caregiver response, if I was notified of changes or concerns what changes if any were ordered, explaining tasks that were done in detail – i.e. t feedings to include type of solution and amount administered, assessment as ordered on Plan of Care. Nurs to sign documentation. (To be by 8/25/17)  Director of Nursing/designee waudit 100% of visit notes week to monitor for compliance. One 100% compliance has been achieved, 25% of visit notes we be audited monthly to monitor compliance. (To begin by 8/25/17).  Director of Nursing will be responsible for monitoring thes corrective actions to ensure th deficiency is corrected and will | MD Sube es gin vill ce iill for | DATE       |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|           | OF CORRECTION                                                                                                           | IDENTIFICATION NUMBER:       | r í   | ULTIPLE CO<br>JILDING | NSTRUCTION                                                             | COMPL  |            |
|-----------|-------------------------------------------------------------------------------------------------------------------------|------------------------------|-------|-----------------------|------------------------------------------------------------------------|--------|------------|
| ANDILAN   | OF CORRECTION                                                                                                           | 15K064                       | B. W. |                       | 00                                                                     | 06/05/ |            |
|           |                                                                                                                         | 101.004                      |       |                       | DDDEGG CITY CTATE TIP CODE                                             | 00/00/ | 2017       |
| NAME OF F | PROVIDER OR SUPPLIEF                                                                                                    | 2                            |       |                       | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                      |        |            |
| AT HOMI   | E HEALTH SERVIC                                                                                                         | CES LLC                      |       |                       | APOLIS, IN 46250                                                       |        |            |
| (X4) ID   | SUMMARY S                                                                                                               | TATEMENT OF DEFICIENCIES     |       | ID                    | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX    | *                                                                                                                       | CY MUST BE PRECEDED BY FULL  |       | PREFIX                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE    | COMPLETION |
| TAG       |                                                                                                                         | LSC IDENTIFYING INFORMATION) | _     | TAG                   | DEFICIENCY)                                                            |        | DATE       |
|           |                                                                                                                         | 7, the visit note indicated  |       |                       |                                                                        |        |            |
|           | the interventions                                                                                                       | •                            |       |                       |                                                                        |        |            |
|           |                                                                                                                         | lministration of tube        |       |                       |                                                                        |        |            |
|           | _                                                                                                                       | indicated that there were    |       |                       |                                                                        |        |            |
|           | significant changes and the physician was<br>notified after the case manager was<br>informed. The visit notes failed to |                              |       |                       |                                                                        |        |            |
|           |                                                                                                                         |                              |       |                       |                                                                        |        |            |
|           |                                                                                                                         |                              |       |                       |                                                                        |        |            |
|           |                                                                                                                         | vas educated in regards to   |       |                       |                                                                        |        |            |
|           | tube feedings, th                                                                                                       | e patient's understanding    |       |                       |                                                                        |        |            |
|           | of tube feedings, type of tube feedings                                                                                 |                              |       |                       |                                                                        |        |            |
|           | administered, what the specific changes                                                                                 |                              |       |                       |                                                                        |        |            |
|           | in condition was, and physician response to notification of said change. The visit                                      |                              |       |                       |                                                                        |        |            |
|           |                                                                                                                         |                              |       |                       |                                                                        |        |            |
|           | note also failed t                                                                                                      | to evidence a blood          |       |                       |                                                                        |        |            |
|           | pressure, temper                                                                                                        | ature, heart rate,           |       |                       |                                                                        |        |            |
|           | respirations, and                                                                                                       | pain assessment.             |       |                       |                                                                        |        |            |
|           | E On 5/0 /                                                                                                              | 5/10 and 5/11/17, the visit  |       |                       |                                                                        |        |            |
|           | notes indicated t                                                                                                       | •                            |       |                       |                                                                        |        |            |
|           |                                                                                                                         |                              |       |                       |                                                                        |        |            |
|           | provided were e                                                                                                         |                              |       |                       |                                                                        |        |            |
|           |                                                                                                                         | f tube feedings as well      |       |                       |                                                                        |        |            |
|           |                                                                                                                         | ere were significant         |       |                       |                                                                        |        |            |
|           | _                                                                                                                       | physician was notified       |       |                       |                                                                        |        |            |
|           |                                                                                                                         | anager was informed.         |       |                       |                                                                        |        |            |
|           |                                                                                                                         | ailed to evidence what       |       |                       |                                                                        |        |            |
|           |                                                                                                                         | regards to tube feedings,    |       |                       |                                                                        |        |            |
|           | _                                                                                                                       | erstanding of tube           |       |                       |                                                                        |        |            |
|           | "                                                                                                                       | e of tube feedings           |       |                       |                                                                        |        |            |
|           |                                                                                                                         | he specific changes in       |       |                       |                                                                        |        |            |
|           | · ·                                                                                                                     | and physician response to    |       |                       |                                                                        |        |            |
|           | notification of sa                                                                                                      | and change.                  |       |                       |                                                                        |        |            |
|           | F. On 5/16                                                                                                              | and 5/24/17, the visit note  |       |                       |                                                                        |        |            |
|           |                                                                                                                         | erventions provided were     |       |                       |                                                                        |        |            |
|           | I                                                                                                                       | -                            | 1     |                       |                                                                        |        | I          |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 86 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                | UILDING | 00                  | COMPL<br>06/05/                                                                                                        | ETED |                            |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------|------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
|                                                                                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                | •       |                     | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                       |      |                            |
| AT HOM                                                                         | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CES LLC                                                                                                                                                                                                                                                                                                                                                                                        |         | INDIAN              | APOLIS, IN 46250                                                                                                       |      |                            |
| (X4) ID<br>PREFIX<br>TAG                                                       | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                              |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | .TE  | (X5)<br>COMPLETION<br>DATE |
|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | f tube feedings. The visit idence the type of tube tered.                                                                                                                                                                                                                                                                                                                                      |         |                     |                                                                                                                        |      |                            |
|                                                                                | G. On 5/25 notes indicated to provided were endedings, medicated and symptoms of g-tube site care. Evidence what we tube feedings, more symptoms of the patient's understoprovided, and are site and the special H. A visit in provided on 6/2/2 incomplete and cardiovascular, goneurological / more genitourinary, provided on genitourinary, provided incomplete and cardiovascular, goneurological / more genitourinary, goneurological / more genitouri | and 5/30/17, the visit he interventions ducation of g-tube ation instruction, signs of disease process, and The visit note failed to was educated in regards to redications, and signs / e disease process, the anding of the education of assessment of the g-tube ific "care" provided.  ote on 5/26/17, was ote on 5/26/17, was failed to include gastrointestinal, ental status, almonary, |         |                     |                                                                                                                        |      |                            |
|                                                                                | also failed to inc                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | erventions, and vices provided. The note clude a signature with the agency provided                                                                                                                                                                                                                                                                                                            |         |                     |                                                                                                                        |      |                            |
|                                                                                | assessment of th<br>gastrointestinal,<br>status, genitourin<br>musculoskeletal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | e that evidenced an e cardiovascular, neurological / mental nary, pulmonary, , integumentary systems dence a pain assessment,                                                                                                                                                                                                                                                                  |         |                     |                                                                                                                        |      |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 87 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|               | OF CORRECTION                                                               | IDENTIFICATION NUMBER:                                    |      | IULTIPLE CO<br>UILDING | NSTRUCTION 00                                                                         | (X3) DATE<br>COMPL |            |
|---------------|-----------------------------------------------------------------------------|-----------------------------------------------------------|------|------------------------|---------------------------------------------------------------------------------------|--------------------|------------|
|               |                                                                             | 15K064                                                    | B. W |                        | <u>oo                                   </u>                                          | 06/05/             |            |
|               |                                                                             |                                                           |      | STREET A               | ADDRESS, CITY, STATE, ZIP CODE                                                        |                    |            |
| NAME OF I     | PROVIDER OR SUPPLIEF                                                        | R                                                         |      |                        | 82ND ST STE 216                                                                       |                    |            |
| AT HOM        | E HEALTH SERVIC                                                             | ES LLC                                                    |      | INDIAN                 | APOLIS, IN 46250                                                                      |                    |            |
| (X4) ID       |                                                                             | TATEMENT OF DEFICIENCIES                                  |      | ID                     | PROVIDER'S PLAN OF CORRECTION                                                         |                    | (X5)       |
| PREFIX<br>TAG |                                                                             | CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) |      | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                 | COMPLETION |
| TAG           |                                                                             | d professional services                                   |      | TAG                    | DLI ICILI (CT)                                                                        |                    | DATE       |
|               | provided.                                                                   | a professional services                                   |      |                        |                                                                                       |                    |            |
|               | provided.                                                                   |                                                           |      |                        |                                                                                       |                    |            |
|               | I. On 5/31 a                                                                | and 6/1/17, the visit note                                |      |                        |                                                                                       |                    |            |
|               |                                                                             | erventions provided was                                   |      |                        |                                                                                       |                    |            |
|               | education of g-tube feedings, medication instruction, signs and symptoms of |                                                           |      |                        |                                                                                       |                    |            |
|               |                                                                             |                                                           |      |                        |                                                                                       |                    |            |
|               | disease process, and g-tube site care. The                                  |                                                           |      |                        |                                                                                       |                    |            |
|               | visit note also indicated the patient's                                     |                                                           |      |                        |                                                                                       |                    |            |
|               | medications were reconciled per phone                                       |                                                           |      |                        |                                                                                       |                    |            |
|               | with the physician. The visit note failed                                   |                                                           |      |                        |                                                                                       |                    |            |
|               | to evidence what was educated in regards                                    |                                                           |      |                        |                                                                                       |                    |            |
|               | I -                                                                         | medications, and signs /                                  |      |                        |                                                                                       |                    |            |
|               | ' '                                                                         | e disease process, the                                    |      |                        |                                                                                       |                    |            |
|               | l -                                                                         | anding of the education assessment of the g-tube          |      |                        |                                                                                       |                    |            |
|               | l *                                                                         | ific "care" provided as                                   |      |                        |                                                                                       |                    |            |
|               |                                                                             | cations that were                                         |      |                        |                                                                                       |                    |            |
|               | reconciled with                                                             |                                                           |      |                        |                                                                                       |                    |            |
|               |                                                                             | and projection.                                           |      |                        |                                                                                       |                    |            |
|               | J. On 6/2/1'                                                                | 7, the visit note indicated                               |      |                        |                                                                                       |                    |            |
|               | the interventions                                                           | provided was education                                    |      |                        |                                                                                       |                    |            |
|               | of g-tube feeding                                                           | gs, medication                                            |      |                        |                                                                                       |                    |            |
|               | 1                                                                           | s and symptoms of                                         |      |                        |                                                                                       |                    |            |
|               |                                                                             | and g-tube site care. The                                 |      |                        |                                                                                       |                    |            |
|               |                                                                             | ed the spouse notified                                    |      |                        |                                                                                       |                    |            |
|               |                                                                             | d to "see narrative." The                                 |      |                        |                                                                                       |                    |            |
|               |                                                                             | to evidence what was                                      |      |                        |                                                                                       |                    |            |
|               | _                                                                           | rds to tube feedings,                                     |      |                        |                                                                                       |                    |            |
|               |                                                                             | l signs / symptoms of the                                 |      |                        |                                                                                       |                    |            |
|               | disease process,                                                            | the patient's f the education provided,                   |      |                        |                                                                                       |                    |            |
|               | I -                                                                         | nt of the g-tube site and                                 |      |                        |                                                                                       |                    |            |
|               |                                                                             | e" provided as well as the                                |      |                        |                                                                                       |                    |            |
|               | and specific car                                                            | provided as well as the                                   |      |                        |                                                                                       |                    |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 88 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                             | ľ                                                                                                                                                                                                                                     | ILDING | <u>00</u>           | COMPL<br>06/05/                                                                                                         | ETED |                            |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------|-------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
| NAME OF F                                             | PROVIDER OR SUPPLIER                                                                                                                                                        |                                                                                                                                                                                                                                       |        |                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                       |      |                            |
| AT HOMI                                               | E HEALTH SERVIC                                                                                                                                                             | ES LLC                                                                                                                                                                                                                                |        |                     | APOLIS, IN 46250                                                                                                        |      |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                              | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                     |        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE   | (X5)<br>COMPLETION<br>DATE |
|                                                       | "narrative" in reg<br>spouse physician                                                                                                                                      | gards to the patient's notification.                                                                                                                                                                                                  |        |                     |                                                                                                                         |      |                            |
|                                                       | Services and Em<br>Assistant Director<br>had no further in                                                                                                                  | relation to the above                                                                                                                                                                                                                 |        |                     |                                                                                                                         |      |                            |
|                                                       | further informati<br>the exit conferen                                                                                                                                      | d Employee B, had no on or documentation by ce on 6/5/17 at 3:50 p.m.                                                                                                                                                                 |        |                     |                                                                                                                         |      |                            |
|                                                       | Nursing Services The Licensed Pra                                                                                                                                           | olicy titled "Skilled " C - 200, indicated " actical Nurse Assists aing appropriate self care                                                                                                                                         |        |                     |                                                                                                                         |      |                            |
| G 0202<br>Bldg. 00                                    | 484.36<br>HOME HEALTH A                                                                                                                                                     | IDE SERVICES                                                                                                                                                                                                                          |        |                     |                                                                                                                         |      | I                          |
| , Diag. 50                                            | the agency failed<br>health aide writte<br>failed to coincide<br>of care to include<br>diagnosis(es), dia<br>failed to be speci<br>in relation to free<br>visits, frequency | review and interview, to ensure that the home en patient instructions with the physician plan e the patient et, mental status, and fic to the patient needs quency and duration of of tasks to be performed 7 out of 7 active records | G 02   | 202                 | See G224, G225, G229, G230                                                                                              |      | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 89 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMEN  | NT OF DEFICIENCIES                                                                                                                                                                         | X1) PROVIDER/SUPPLIER/CLIA     | (X2) M | IULTIPLE CO | NSTRUCTION                                                         | (X3) DATE | SURVEY     |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------|-------------|--------------------------------------------------------------------|-----------|------------|
| AND PLAN  | OF CORRECTION                                                                                                                                                                              | IDENTIFICATION NUMBER:         | A. Bl  | UILDING     | 00                                                                 | COMPI     | LETED      |
|           |                                                                                                                                                                                            | 15K064                         | B. W   | ING         |                                                                    | 06/05     | /2017      |
|           |                                                                                                                                                                                            |                                |        | STREET A    | ADDRESS, CITY, STATE, ZIP CODE                                     |           |            |
| NAME OF I | PROVIDER OR SUPPLIE                                                                                                                                                                        | R                              |        |             | 82ND ST STE 216                                                    |           |            |
| AT HOM    | E HEALTH SERVI                                                                                                                                                                             | CES LLC                        |        | INDIAN      | APOLIS, IN 46250                                                   |           |            |
| (X4) ID   | SUMMARY S                                                                                                                                                                                  | STATEMENT OF DEFICIENCIES      | 1      | ID          |                                                                    |           | (X5)       |
| PREFIX    |                                                                                                                                                                                            | NCY MUST BE PRECEDED BY FULL   |        | PREFIX      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |           | COMPLETION |
| TAG       | REGULATORY OF                                                                                                                                                                              | R LSC IDENTIFYING INFORMATION) |        | TAG         | CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                    | AIE       | DATE       |
|           | reviewed of pat                                                                                                                                                                            | ients with home health         |        |             |                                                                    |           |            |
|           | 1                                                                                                                                                                                          | a sample of 10 (See G          |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | follow the plan of care in     |        |             |                                                                    |           |            |
|           | relation to light house keeping duties in 1 out of 2 home health aide visits conducted in a sample of 5 home visits (See G 225); failed to ensure that a Registered Nurse conducted a home |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           | "                                                                                                                                                                                          | ervisory visit every 14        |        |             |                                                                    |           |            |
|           | _                                                                                                                                                                                          | _                              |        |             |                                                                    |           |            |
|           | days in 3 out of 3 active records reviewed of patients receiving a home health aide with skilled nursing services in a sample                                                              |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | and failed to ensure that a    |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | se conducted a home            |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | ervisory visit every 60        |        |             |                                                                    |           |            |
|           | 1 *                                                                                                                                                                                        | 5 active records reviewed      |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | aide only services in a        |        |             |                                                                    |           |            |
|           | sample of 10 (S                                                                                                                                                                            | ee G 230).                     |        |             |                                                                    |           |            |
|           | The cumulative                                                                                                                                                                             | effect of this systemic        |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | d in the agency being out      |        |             |                                                                    |           |            |
|           | _                                                                                                                                                                                          | with the Condition of          |        |             |                                                                    |           |            |
|           | _                                                                                                                                                                                          | 4.36: Home Health Aide         |        |             |                                                                    |           |            |
|           | Services.                                                                                                                                                                                  | T.JO. HOME HEARM ARE           |        |             |                                                                    |           |            |
|           | Services.                                                                                                                                                                                  |                                |        |             |                                                                    |           |            |
|           | The cumulative                                                                                                                                                                             | effect of these systemic       |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            | ed in the home health          |        |             |                                                                    |           |            |
|           | 1 *                                                                                                                                                                                        | ty to ensure the provision     |        |             |                                                                    |           |            |
|           | of quality health                                                                                                                                                                          | -                              |        |             |                                                                    |           |            |
|           | environment.                                                                                                                                                                               | i care iii a saic              |        |             |                                                                    |           |            |
|           | environment.                                                                                                                                                                               |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |
|           |                                                                                                                                                                                            |                                |        |             |                                                                    |           |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 90 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMEN           | T OF DEFICIENCIES                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                              | (X2) M | ULTIPLE CO | ONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X3) DATE S                                     | SURVEY     |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------|
| AND PLAN           | OF CORRECTION                                                                                                                                                                                                                                                                                                               | IDENTIFICATION NUMBER:                                                                                                                                                                                                  | A. BU  | JILDING    | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | COMPL                                           | ETED       |
|                    |                                                                                                                                                                                                                                                                                                                             | 15K064                                                                                                                                                                                                                  | B. Wl  | NG         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 06/05/                                          | 2017       |
|                    |                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                         |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <u> </u>                                        |            |
| NAME OF F          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                         |        |            | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                 |            |
| AT HOMI            | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                             | ES LLC                                                                                                                                                                                                                  |        |            | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |            |
| (X4) ID            | SUMMARY S                                                                                                                                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                |        | ID         | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                 | (X5)       |
| PREFIX             | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                              | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                             |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | TE                                              | COMPLETION |
| TAG                |                                                                                                                                                                                                                                                                                                                             | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                            |        | TAG        | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 | DATE       |
| G 0224<br>Bldg. 00 | HEALTH AIDE Written patient can home health aide registered nurse of professional who if supervision of the paragraph (d) of the Based on record the agency failed                                                                                                                                                          | DUTIES OF HOME  re instructions for the must be prepared by the or other appropriate s responsible for the home health aide undernis section.  review and interview, It to ensure that the home en patient instructions | G 0    | 224        | Director of Nursing/designee vin-service nurses on ensuring home health aide plan of care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                 | 08/25/2017 |
|                    | failed to coincide of care to include diagnosis(es), die failed to be specin relation to free visits, frequency and diagnoses in reviewed of patie aide services in a 6, 7, 8 and 9)  Findings include  1. The clinical results SOC (start of care plan of care for the 4/9/17 to 6/7/17, aide services up days per week to | e with the physician plan e the patient et, mental status, and iffic to the patient needs quency and duration of of tasks to be performed 7 out of 7 active records ents with home health a sample of 10. (#2, 3, 5,    |        |            | specific, for each patient, regarding tasks aide to perform frequency and duration of visit and frequency of tasks to be performed. (To be completed 18/25/17)  Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on ensuring home heat aide plan of care is specific, for each patient, regarding tasks at to perform, frequency and duration of visits and frequency tasks to be performed. (To beging by 8/25/17)  Director of Nursing/designee valudit 100% of aide plans of cate monitor for compliance with making sure it specific regarding tasks aide to perform, frequent and duration of visits and frequency of tasks to be performed. Once 100% compliance is achieved, 25% caide plans of care will be audit | by  ion alth ar aide  y of gin  vill are  ng cy |            |
|                    | living, meal prep, medication reminders, and light housekeeping. The nutrition requirement (locator 16) indicated the                                                                                                                                                                                                       |                                                                                                                                                                                                                         |        |            | monthly to monitor for compliance. (To begin by 8/25/17).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                 |            |
|                    | I natient was on a                                                                                                                                                                                                                                                                                                          | mechanical soft diet and                                                                                                                                                                                                | - 1    |            | I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                 |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 91 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE<br>A. BUILDING 00 COMPLETED |      |               |                                                                    |        |                    |
|----------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------|------|---------------|--------------------------------------------------------------------|--------|--------------------|
|                                                                                                    |                                                | 15K064                                                                 | B. W | ING           |                                                                    | 06/05/ | 2017               |
| NAME OF I                                                                                          | PROVIDER OR SUPPLIEF                           | 8                                                                      |      |               | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
| AT HOM                                                                                             | E HEALTH SERVIC                                | CES LLC                                                                |      |               | 82ND ST STE 216<br>APOLIS, IN 46250                                |        |                    |
| (X4) ID                                                                                            |                                                | TATEMENT OF DEFICIENCIES                                               |      | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| PREFIX<br>TAG                                                                                      | `                                              | ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)             |      | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                     | ГЕ     | COMPLETION<br>DATE |
|                                                                                                    | the patient was a                              |                                                                        |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | tions (locator 18) ient was hearing and                                |      |               |                                                                    |        |                    |
|                                                                                                    | •                                              | . The mental status                                                    |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | cated the patient was non                                              |      |               |                                                                    |        |                    |
|                                                                                                    | - verbal. The pa                               | tient's diagnoses                                                      |      |               |                                                                    |        |                    |
|                                                                                                    | included, but not limited to, Alzheimer's      |                                                                        |      |               |                                                                    |        |                    |
|                                                                                                    | disease and dementia with behavioral           |                                                                        |      |               |                                                                    |        |                    |
|                                                                                                    | disturbances.  A. The home health aide written |                                                                        |      |               |                                                                    |        |                    |
|                                                                                                    |                                                |                                                                        |      |               |                                                                    |        |                    |
|                                                                                                    | patient instruction                            | ons indicated the patient                                              |      |               |                                                                    |        |                    |
|                                                                                                    | was an assist wit                              | •                                                                      |      |               |                                                                    |        |                    |
|                                                                                                    | commode, elimi                                 | _                                                                      |      |               |                                                                    |        |                    |
|                                                                                                    | -                                              | neelchair. The home                                                    |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | en patient instructions                                                |      |               |                                                                    |        |                    |
|                                                                                                    | -                                              | ient was on a regular<br>health aide written                           |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | ons included a complete                                                |      |               |                                                                    |        |                    |
|                                                                                                    | _                                              | spection, foot care, light                                             |      |               |                                                                    |        |                    |
|                                                                                                    | ĺ .                                            | the bathroom, kitchen,                                                 |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | nen change, nail care,                                                 |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | s, hair care, meal prep,                                               |      |               |                                                                    |        |                    |
|                                                                                                    | medication remi                                | nder, oral care, shampoo,                                              |      |               |                                                                    |        |                    |
|                                                                                                    | wash clothes, an                               | d placement / removal of                                               |      |               |                                                                    |        |                    |
|                                                                                                    | an orthopedic br                               | ace. The home health                                                   |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | ructions failed to be                                                  |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | incide with the physician                                              |      |               |                                                                    |        |                    |
|                                                                                                    | •                                              | e home health aide                                                     |      |               |                                                                    |        |                    |
|                                                                                                    |                                                | ons failed to be specific                                              |      |               |                                                                    |        |                    |
|                                                                                                    | _                                              | uency and duration of                                                  |      |               |                                                                    |        |                    |
|                                                                                                    | visits, frequency                              | OI LASKS TO DE                                                         |      |               |                                                                    |        |                    |
|                                                                                                    | performed.                                     |                                                                        |      |               |                                                                    |        |                    |
|                                                                                                    |                                                |                                                                        |      |               |                                                                    |        |                    |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 92 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                                                                                                                                                                            | onstruction<br>00   | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                  |                      |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                       | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>8 82ND ST STE 216<br>NAPOLIS, IN 46250                                               |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                                                                            | SOC 11/28/16, if the certification 7/25/17, with order services up to 8 week to assist weak to assist week to assist week to assist weak to assist we we were to assist we we were to assist we were to assist we were to assist we were to a | ecord for patient #3, ncluded a plan of care for period of 5/27/17 to ders for home aide hours per day, 7 days per ith personal care, g, activities of daily p, medication reminders, eeping. The nutrition ator 16) indicated the s carbohydrate controlled carbohydrate intake is set at a particular value blood sugars). The tes included, but not domyolysis, type 2 disorder, morbid obesity, and hypertension. |                     |                                                                                                                        |                      |
|                                                                                                            | patient instruction was on a carb concentrated swaide written pating a shower, skin in housekeeping in and bedroom, linguare, meal prep, oral care, shamp The diet in the hinstructions failed physician plan of specific and inclinations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ne health aide written ons indicated the patient ontrolled diet and no eets. The home health eent instructions included aspection, foot care, light the bathroom, kitchen, nen change, nail care, hair medication reminder, oo, and wash clothes. ome health aide written ed to coincide with the f care and failed to be ude frequency and s, frequency of tasks to                                                  |                     |                                                                                                                        |                      |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 93 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                                                                                                                                             |                     | onstruction<br>00                                                                                                     | (X3) DATE SURVEY COMPLETED 06/05/2017 |  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|
|                          | PROVIDER OR SUPPLIER E HEALTH SERVICES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                 |                                       |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | (X5) COMPLETION DATE                  |  |
|                          | be performed. The nail and foot care failed to be specific with indicating that the home health aide would not perform trimming of nails due to the patient diabetes.                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                                       |                                       |  |
|                          | 3. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 5/20/17 to 7/18/17, with orders for home health aide services up to 6 hours per day, 5 days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping. The patient's diagnoses included, but not limited to, Tuberous sclerosis, dementia, weakness, and epilepsy / epileptic syndrome with seizures. |                     |                                                                                                                       |                                       |  |
|                          | A. The home health aide written patient instructions included to assist the patient with a shower, skin inspection, transfers, walker, light housekeeping in the bathroom, kitchen, and bedroom, linen change, foot care, dressing, ambulation, bed, hair care, meal prep, medication reminder, oral care, shampoo, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed.                |                     |                                                                                                                       |                                       |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 94 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLI IDENTIFICATION NUM 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | IER/CLIA (X2) MULTIPLE CO MBER: A. BUILDING B. WING                                                                                                    | ONSTRUCTION  00                                                                                                        | (X3) DATE SURVEY COMPLETED 06/05/2017 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6525 E                                                                                                                                                 | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                                 |                                       |
| (X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INFO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ED BY FULL PREFIX                                                                                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE                  |
| 4. The clinical record for patient #SOC 1/30/17, included a plan of che certification period of 3/31/17 5/29/17, with orders for home head services 1 - 2 visits per day up to 3 a day, 7 days a week to assist with personal care, bathing, dressing, and of daily living, meal prep, medicate reminders, and light housekeeping care plan. The patient diagnoses included, but not limited to, Spina urostomy, diabetes, and constipation.  A. The home health aide writt patient instructions included to assignation with dressing, bed, eliminal mobility, shower, skin inspection, transfers, equipment care, hair care prep, medication reminder, oral care positioning, peri care after inconting episode, shampoo, nail care, light housekeeping in the bathroom, kitt and bedroom, linen change, and we clothes. The home health aide writinstructions failed to be specific are include frequency and duration of frequency of tasks to be performed nail care failed to be specific with indicating that the home health aid would not perform trimming of nato the patient diabetes.  5. The clinical record for patient #SOC 12/31/16, included a plan of | are for to lth aide 3 hours a ctivities tion g per bifida, on.  ten sist the ation, e, meal are, nent chen, vash itten and visits, d. The  de tils due |                                                                                                                        |                                       |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 95 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICES LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250  (X5) |            | OF DEFICIENCIES                                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ULTIPLE CO.<br>JILDING | NSTRUCTION                 | (X3) DATE |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---|------------------------|----------------------------|-----------|------------|
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250  (X5)       | ANDILANC   | or connection                                                                                                                                          |                                                   |   |                        | 00                         |           |            |
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION  (X5)                                                           |            |                                                                                                                                                        | 101004                                            |   |                        | DDDEGG CITY OTATE ZID CODE | 00/00/    | 2011       |
| AT HOME HEALTH SERVICES LLC INDIANAPOLIS, IN 46250  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)                                                                    | NAME OF PI | ROVIDER OR SUPPLIER                                                                                                                                    |                                                   |   |                        |                            |           |            |
| PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                          | AT HOME    | HEALTH SERVIC                                                                                                                                          | ES LLC                                            |   |                        |                            |           |            |
|                                                                                                                                                                                                        |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| CROSS-REFERENCED TO THE APPROPRIATE                                                                                                                                                                    | PREFIX     |                                                                                                                                                        |                                                   |   | PREFIX                 |                            | TE        | COMPLETION |
| THE REGULATOR OR ESC IDEATH TIMO IN ORGANIZATION                                                                                                                                                       | IAG        |                                                                                                                                                        | · · · · · · · · · · · · · · · · · · ·             | + | TAG                    | DEFICIENCT)                |           | DATE       |
| the certification period of 4/9/17 to                                                                                                                                                                  |            |                                                                                                                                                        | •                                                 |   |                        |                            |           |            |
| 6/7/17, with orders for home health aide                                                                                                                                                               |            | · ·                                                                                                                                                    |                                                   |   |                        |                            |           |            |
| services up to 6 hours per day, 7 days a                                                                                                                                                               |            | •                                                                                                                                                      |                                                   |   |                        |                            |           |            |
| week. to assist with personal care,                                                                                                                                                                    |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| bathing, dressing, activities of daily                                                                                                                                                                 |            | •                                                                                                                                                      | •                                                 |   |                        |                            |           |            |
| living, meal prep, medication reminders,                                                                                                                                                               |            | and light housekeeping per care plan.                                                                                                                  |                                                   |   |                        |                            |           |            |
|                                                                                                                                                                                                        |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
|                                                                                                                                                                                                        |            | The patient diagnoses included, but not limited to, venous insufficiency, convulsions, diabetes, and venous embolism.  A. The home health aide written |                                                   |   |                        |                            |           |            |
|                                                                                                                                                                                                        |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
|                                                                                                                                                                                                        |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| embolism.                                                                                                                                                                                              |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| A. The home health aide written                                                                                                                                                                        |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| patient instructions included to assist the                                                                                                                                                            |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| patient with ambulation, chair, dressing,                                                                                                                                                              |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| bed, elimination, mobility, bed bath, skin                                                                                                                                                             |            | •                                                                                                                                                      |                                                   |   |                        |                            |           |            |
| inspection, foot care, commode, transfers,                                                                                                                                                             |            |                                                                                                                                                        | • .                                               |   |                        |                            |           |            |
| walker, wheel chair, equipment care, hair                                                                                                                                                              |            | •                                                                                                                                                      |                                                   |   |                        |                            |           |            |
| care, meal prep, feeding, medication                                                                                                                                                                   |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| reminder, oral care, positioning, peri care                                                                                                                                                            |            |                                                                                                                                                        | <u> </u>                                          |   |                        |                            |           |            |
| after incontinent episode, shampoo, light                                                                                                                                                              |            | ,                                                                                                                                                      | . 1                                               |   |                        |                            |           |            |
| housekeeping in the bathroom, kitchen,                                                                                                                                                                 |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| and bedroom, linen change, and wash                                                                                                                                                                    |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| clothes. The home health aide written                                                                                                                                                                  |            |                                                                                                                                                        | <b>O</b> /                                        |   |                        |                            |           |            |
| instructions failed to be specific and                                                                                                                                                                 |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| include frequency and duration of visits,                                                                                                                                                              |            |                                                                                                                                                        | _                                                 |   |                        |                            |           |            |
| frequency of tasks to be performed. The                                                                                                                                                                |            | •                                                                                                                                                      | •                                                 |   |                        |                            |           |            |
| foot care failed to be specific with                                                                                                                                                                   |            |                                                                                                                                                        | -                                                 |   |                        |                            |           |            |
| indicating that the home health aide                                                                                                                                                                   |            |                                                                                                                                                        | •                                                 |   |                        |                            |           |            |
| would not perform trimming of nails due                                                                                                                                                                |            | _                                                                                                                                                      |                                                   |   |                        |                            |           |            |
| to the patient diabetes.                                                                                                                                                                               |            |                                                                                                                                                        |                                                   |   |                        |                            |           |            |
| to the patient diabetes.                                                                                                                                                                               |            | to the patient dia                                                                                                                                     | ootos.                                            |   |                        |                            |           |            |
| 6. The clinical record for patient #8,                                                                                                                                                                 |            | 6. The clinical r                                                                                                                                      | ecord for patient #8.                             |   |                        |                            |           |            |
| SOC 8/3/16, included a plan of care for                                                                                                                                                                |            |                                                                                                                                                        | _                                                 |   |                        |                            |           |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 96 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                          | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION 00                                                                                                | (X3) DATE :<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                 |                                                                                                                                                                                                                                                                   | 6525 E                                     | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                      | •                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                          | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ) BE                           | (X5)<br>COMPLETION<br>DATE |
|                          | 5/29/17, with ord<br>services up to 8 week. to assist week. to assist week bathing, dressing living, meal prepand light housek  A. The homopatient instruction                          | period of 3/3117 to ders for home health aide hours per day, 7 days a with personal care, g, activities of daily n, medication reminders, eeping per care plan.  the health aide written the solimination, hed both                                               |                                            |                                                                                                               |                                |                            |
|                          | skin inspection,<br>transfers, inspection,<br>prep, medication<br>positioning, peri-<br>episode, light hobathroom, kitcher<br>change, and was<br>health aide writt<br>be specific and i | delimination, bed bath, nail care, clean dentures, t dressing, hair care, meal reminder, oral care, care after incontinent usekeeping in the en, and bedroom, linen th clothes. The home en instructions failed to include frequency and s, frequency of tasks to |                                            |                                                                                                               |                                |                            |
|                          | SOC 7/8/16, was communication indicated the hor providing servic days a week to a hygiene, transfer / setup, and light of care for the cere                                             | log dated 5/16/17, me health aide was es up to 5 hours a day, 7 ssist with grooming, rs, medication reminders housekeeping. The plan ertification period 5/4/17 to be provided upon                                                                               |                                            |                                                                                                               |                                |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 97 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTII<br>A. BUILDII<br>B. WING                                                                                                                                                                                                                                    |                                                                                     | NSTRUCTION  00 | (X3) DATE<br>COMPL<br>06/05/                                                                                       | ETED |                            |  |
|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------|--------------------------------------------------------------------------------------------------------------------|------|----------------------------|--|
|                                                                                                            | PROVIDER OR SUPPLIEI<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                |                                                                                                                    |      |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)                                                                                                                                                                                  | ID<br>PREF<br>TA                                                                    | IX             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE |  |
|                                                                                                            | patient instruction patient with char elimination, mode inspection, transequipment care, care, meal prep, oral care, position housekeeping in and bedroom, lingle clothes. The host instructions failed include frequency of tas.  8. Employee B Services and Employee A, Administration in findings on 6/2/  9. Employee A, Administrator, in that she was away information need aide care plan.  10. An undated Health Aide / Control (HHA) Care To provide a service of the control o | the bathroom, kitchen, nen change, and wash me health aide written ed to be specific and ey and duration of visits, ks to be performed.  the Director of Clinical aployee C, the Interim or of Clinical Services, aformation or n relation to the above 17 at 4:00 p.m. |                                                                                     |                |                                                                                                                    |      |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 98 of 247

|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A. BU    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       | (X3) DATE SURVEY COMPLETED 06/05/2017 |  |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------|--|
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       |                                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ΓE                                    | (X5)<br>COMPLETION<br>DATE            |  |
| G 0225<br>Bldg. 00       | being served To documentation the individualized to 484.36(c)(2) ASSIGNMENT & I HEALTH AIDE The home health a are ordered by the care and that the aperform under state Based on record the home health plan of care in reckeeping duties in aide visits conduct home visits. (#2) Findings include  1. The clinical responsible for the solution of care for the solution of care for the solution of care, bathing, dresponsible for the solution of the | nat the client's care is his / her specific needs.  DUTIES OF HOME  aide provides services that a physician in the plan of aide is permitted to the law.  review and interview, aide failed to follow the elation to light house in 1 out of 2 home health acted in a sample of 5.  Execord for patient #2, and the certification period of with orders for home are up to 8 hours per day, to assist with personal acessing, activities of daily of medication reminders, eeping per care plan.  The health aide written are indicated the home | G 0      | 225                                                                                 | Director of Nursing/designee vin-service aides on following patient's care plan as written be nurse and ordered by MD. (To done by 8/25/17) Director of Nursing will be responsible to ensure to orientation of newly hired aider includes training on following patient's care plan as written be nurse and ordered by MD. (To begin by 8/25/17) Director of Nursing/designee vinus audit 100% of aide care plans compliance until 100% compliance is achieved. Once 100% compliance is achieved. Once 100% compliance is achieved. Director of Nursing/designee vinus audit 25% of aide care plans monthly to monitor compliance (To begin by 8/25/17) Director of Nursing/designee vin-service nurses on specifying what housekeeping tasks aide to perform for each patient. It is be clearly indicated on care plans (To be done by 8/25/17) Director of Nursing will be responsible to answer orientation. | by be s y vill for vill s is will an. | 08/25/2017                            |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |          |                                                                                     | responsible to ensure orientati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 011                                   |                                       |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 99 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                              | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI |       |          |                                                                                       |        |            |
|------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------|-------|----------|---------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                | IDENTIFICATION NUMBER:                     |       | JILDING  | 00                                                                                    | COMPL  |            |
|                                                      |                                                              | 15K064                                     | B. WI | NG       |                                                                                       | 06/05/ | /2017      |
| NAME OF F                                            | PROVIDER OR SUPPLIER                                         | •                                          | _     | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                        | -      |            |
|                                                      |                                                              |                                            |       |          | 82ND ST STE 216                                                                       |        |            |
| AT HOMI                                              | E HEALTH SERVIC                                              | ES LLC                                     |       | INDIAN   | APOLIS, IN 46250                                                                      |        |            |
| (X4) ID                                              |                                                              | TATEMENT OF DEFICIENCIES                   |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                         |        | (X5)       |
| PREFIX                                               | `                                                            | CY MUST BE PRECEDED BY FULL                |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  |                                                              | LSC IDENTIFYING INFORMATION)               |       | TAG      | ·                                                                                     |        | DATE       |
|                                                      |                                                              | uring home visit on                        |       |          | of newly hired nurses includes<br>training on specifying what                         | i      |            |
|                                                      |                                                              | m., the patient's bedroom                  |       |          | housekeeping tasks aide is to                                                         |        |            |
|                                                      |                                                              | e thick layer of dark                      |       |          | perform for each patient. It will                                                     | be     |            |
|                                                      | colored dust on t                                            | he furniture and ceiling                   |       |          | clearly indicated on care plan.                                                       | (To    |            |
|                                                      | fan.                                                         |                                            |       |          | begin by 8/25/17)                                                                     | vill   |            |
|                                                      |                                                              |                                            |       |          | Director of Nursing/designee valudit 100% of aide care plans                          |        |            |
|                                                      | B. During th                                                 | he home visit with                         |       |          | compliance until 100%                                                                 | .01    |            |
|                                                      | Employee F, a ho                                             | ome health aide, the                       |       |          | compliance is achieved. Once                                                          |        |            |
|                                                      | Director of Clini                                            | cal Services observed                      |       |          | 100% compliance is achieved                                                           |        |            |
|                                                      | the dust, including                                          | ng the dust on the ceiling                 |       |          | Director of Nursing/designee v                                                        | vill   |            |
|                                                      | fan, and indicate                                            | d dusting was part of the                  |       |          | audit 25% of aide care plans<br>monthly to monitor compliance                         | 2      |            |
|                                                      | "light housekeep                                             | ing" in the patient's                      |       |          | (To begin by 8/25/17)                                                                 |        |            |
|                                                      | bedroom. The h                                               | ome health aide failed to                  |       |          | , , , , , , , , , , , , , , , , , , , ,                                               |        |            |
|                                                      | follow the plan of                                           | of care.                                   |       |          |                                                                                       |        |            |
|                                                      | •                                                            |                                            |       |          |                                                                                       |        |            |
|                                                      | 2. The clinical re                                           | ecord for patient #5,                      |       |          |                                                                                       |        |            |
|                                                      | SOC 11/21/16, ii                                             | ncluded a plan of care for                 |       |          |                                                                                       |        |            |
|                                                      | the certification                                            | period of 5/20/17 to                       |       |          |                                                                                       |        |            |
|                                                      | 7/18/17, with ord                                            | ders for home health aide                  |       |          |                                                                                       |        |            |
|                                                      |                                                              | hours per day, 5 days per                  |       |          |                                                                                       |        |            |
|                                                      |                                                              | ith personal care,                         |       |          |                                                                                       |        |            |
|                                                      |                                                              | g, activities of daily                     |       |          |                                                                                       |        |            |
|                                                      |                                                              | o, medication reminders,                   |       |          |                                                                                       |        |            |
|                                                      | 0, 1 1                                                       | eeping per care plan.                      |       |          |                                                                                       |        |            |
|                                                      | and inguit nousek                                            |                                            |       |          |                                                                                       |        |            |
|                                                      | A The hom                                                    | e health aide written                      |       |          |                                                                                       |        |            |
|                                                      |                                                              | ns indicated the home                      |       |          |                                                                                       |        |            |
|                                                      | _ ^                                                          | to provide a shower to                     |       |          |                                                                                       |        |            |
|                                                      | the patient.                                                 | to provide a shower to                     |       |          |                                                                                       |        |            |
|                                                      | nic patient.                                                 |                                            |       |          |                                                                                       |        |            |
|                                                      | B During tl                                                  | he home visit with                         |       |          |                                                                                       |        |            |
|                                                      | B. During the home visit with Employee G, a home health aide |                                            |       |          |                                                                                       |        |            |
|                                                      |                                                              | e patient would receive a                  |       |          |                                                                                       |        |            |
|                                                      |                                                              | lay and Wednesday, but                     |       |          |                                                                                       |        |            |
| 1                                                    | 1 2110 M CT OH 1810 HO                                       | iav anu weunesuav. Dul                     | 1     |          |                                                                                       |        | 1          |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV                                                                           |                                                                                     |         | SURVEY                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                 | IDENTIFICATION NUMBER:                                                                                              | A. BU                                                                               | JILDING | 00                                                                                                                                                                                                                                                                                                                                                                                   | COMPL              | ETED       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                               | 15K064                                                                                                              | B. WI                                                                               | ING     |                                                                                                                                                                                                                                                                                                                                                                                      | 06/05/             | 2017       |
|                                                      | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |         |                                                                                                                                                                                                                                                                                                                                                                                      |                    |            |
| (X4) ID                                              | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                     | FATEMENT OF DEFICIENCIES                                                                                            | ID                                                                                  |         | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                        |                    | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                | CY MUST BE PRECEDED BY FULL                                                                                         |                                                                                     | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE                                                                                                                                                                                                                                                                                                             | re .               | COMPLETION |
| TAG                                                  | REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                 | LSC IDENTIFYING INFORMATION)                                                                                        |                                                                                     | TAG     | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                          | _                  | DATE       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                               | I off at the sink on<br>me health aide failed to<br>of care.                                                        |                                                                                     |         |                                                                                                                                                                                                                                                                                                                                                                                      |                    |            |
| G 0229<br>Bldg. 00                                   |                                                                                                                                                                                                                                                                                                                                                                                               | rse (or another<br>ribed in paragraph (d)(1) of<br>make an on-site visit to                                         |                                                                                     |         |                                                                                                                                                                                                                                                                                                                                                                                      |                    |            |
|                                                      | the patient's home every 2 weeks.                                                                                                                                                                                                                                                                                                                                                             | no less frequently than review and interview,                                                                       | G 0.                                                                                | 229     | Director of Nursing/designee win-service nurses on supervisir                                                                                                                                                                                                                                                                                                                        | ng                 | 08/25/2017 |
|                                                      | Registered Nurse<br>health aide super<br>days in 3 out of 3<br>of patients receiv                                                                                                                                                                                                                                                                                                             | e conducted a home visory visit every 14 B active records reviewed ving a home health aide ing services in a sample |                                                                                     |         | aide at least every fourteen (14 days in cases where patient is receiving skilled nurse and aid services. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientati of newly hired nurses includes training on supervising aide at                                                                                                                    | e                  |            |
|                                                      | Findings include                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                     |                                                                                     |         | least every fourteen (14) days cases where patient is receivir skilled nurse and aide services                                                                                                                                                                                                                                                                                       | ng                 |            |
|                                                      | <ol> <li>The clinical record for patient #3, SOC 11/28/16, was reviewed and included orders for skilled nursing and home health aide services. The clinical record evidenced a home health aide supervisory visit on 03/24/17 and 5/23/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days.</li> <li>The clinical record for patient #6,</li> </ol> |                                                                                                                     |                                                                                     |         | (To begin by 8/25/17) Director of Nursing/designee waudit 100% of aide supervisory notes weekly until 100% compliance is achieved. Once 100% compliance is achieved, 25% of aide supervisory notes be audited monthly to monitor compliance. (To begin by 8/25/17) Director of Nursing is responsifor monitoring corrective action to this deficiency is corrected a will not recur. | will<br>for<br>ble |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 101 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                   | A. Bl                                                                                                                                                            | A. BUILDING 00  B. WING |                     |                                                                                                                      | COMPLETED 06/05/2017 |                            |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------|
|                                                       | PROVIDER OR SUPPLIEF                                                                                                              |                                                                                                                                                                  |                         | 6525 E 8            | .DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                |                      |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                    | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                               |                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) |                      | (X5)<br>COMPLETION<br>DATE |
|                                                       | orders for skilled<br>health aide servi<br>evidenced a hon<br>visit on 4/21/17<br>clinical record fa<br>health aide supe<br>days. | as reviewed and included d nursing and home ces. The clinical record he health aide supervisory and 5/17/17. The hiled to evidence a home rvisory visit every 14 |                         |                     |                                                                                                                      |                      |                            |
|                                                       | orders for skilled<br>health aide. The<br>evidenced home<br>visit on 1/2/17, 3<br>clinical record fa                              | s reviewed and included d nursing and home eclinical record health aide supervisory 8/1/17 and 4/28/17. The miled to evidence a home revisory visit every 14     |                         |                     |                                                                                                                      |                      |                            |
|                                                       | Services and Em<br>Assistant Direct<br>were aware of th<br>no further inform                                                      | the Director of Clinical aployee C, the Interim or of Clinical Services, as supervisory visits had mation or documentation above findings on m.                  |                         |                     |                                                                                                                      |                      |                            |
|                                                       | further informat                                                                                                                  | the Alternate and Employee B, had no ion or documentation by ace on 6/5/17 at 3:50 p.m.                                                                          |                         |                     |                                                                                                                      |                      |                            |
| G 0230                                                | 484.36(d)(3)<br>SUPERVISION                                                                                                       |                                                                                                                                                                  |                         |                     |                                                                                                                      |                      |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 102 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUILDING 00 COMPLET 06/05/2                                                                                                                                                                                                                                                                               |      |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                              |      | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN<br>REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                            |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TE                                | (X5)<br>COMPLETION<br>DATE |
| Bldg. 00                                                                                                   | a patient who is not care, physical or of speech-language registered nurse in visit to the patient' than every 60 day ensure that the aid patient, each super while the home he patient care.  Based on record the agency failed Registered Nurse health aide super days in 2 out of 30 of home health a sample of 10. (#Findings include 1. The clinical record failed to the | e conducted a home rvisory visit every 60 5 active records reviewed ide only services in a 2 and 5)  ecord for patient #2, re) 3/6/12, was reviewed. ord failed to evidence a alth aide supervisory visit to 5/3/17.  ecord for patient #5, was reviewed. The ailed to evidence a 60 day e supervisory visit | G 0: | 230                 | Director of Nursing/designee vin-service nurses on requirement to supervise aide at least ever sixty (60) days in cases where patient has aide only services. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hurse are trained on requirement to supervise aide at least ever sixty (60) days in cases where patient has aide only services. (To begin by 8/25/17) Director of Nursing/designee vaudit 100% of aide supervisors notes weekly until 100% compliance is achieved. Once 100% compliance is achieved. Once 100% compliance is achieved. 25% of aide supervisory notes be audited monthly to monitor compliance. (To begin by 8/25/17) Director of Nursing is responsifor monitoring corrective action to this deficiency is corrected a will not recur. | ent y ired ent y vill y swill for | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 103 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | r í                                                                               | JILDING                                                                                   | 00                  | COMPL 06/05/                                                                                                          | ETED |                            |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------|------|----------------------------|
|                                                       | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                     |                                                                                                                       |      |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE  | (X5)<br>COMPLETION<br>DATE |
|                                                       | no further inform                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | e supervisory visits had nation or documentation above findings on m.             |                                                                                           |                     |                                                                                                                       |      |                            |
| G 0235                                                | 484.48<br>CLINICAL RECOF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | RDS                                                                               |                                                                                           |                     |                                                                                                                       |      | ,                          |
| Bldg. 00                                              | Based on record review, the agency failed to ensure that visit notes were accessible in an electronic medical record in 1 of 2 closed records reviewed (#1) in a sample of 10, failed to update a clinical record with a correct address location of a patient receiving services in 1 out of 5 home visits conducted (#2), failed to physician orders were written for prn (as needed) visits and that those prn skilled nursing visits were documented in 1 out of 4 records reviewed (#3) of patients with skilled nursing in a sample of 10; failed to ensure electronic medical records identified an employee as a LPN and not an RN in 2 out of 2 records reviewed (#4 and 6) of patients receiving skilled nursing services from Employee E in a sample of 10; failed to ensure visit notes were completed and signed / dated by the clinican in a timely manner in 1 of 8 active records reviewed (#4) in a sample of 10; failed to ensure that the |                                                                                   | G 0                                                                                       | 235                 | See G236                                                                                                              |      | 08/25/2017                 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 104 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                           | ONSTRUCTION  00                                                                     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                                                                                      |                      |  |  |  |
|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--|--|--|
|                                                                                                              | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                            |                      |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                     | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                    | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                              | (X5) COMPLETION DATE |  |  |  |
|                                                                                                              | plan of care in 1 reviewed (#9) in  The cumulative of problem resulted of compliance w Participation 484  The cumulative of problems resulted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | effect of this systemic in the agency being out ith the Condition of 1.48: Clinical Records. effect of these systemic d in the home health y to ensure the provision |                                                                                     |                                                                                                                                                                                                                                            |                      |  |  |  |
| G 0236<br>Bldg. 00                                                                                           | and current finding accepted profession maintained for even health services. In care, the record condentifying information drug, dietary, treat signed and dated notes; copies of support of the ensure that vision an electronic reclosed records record to the ensure that vision and electronic reclosed records record to the ensure that vision and electronic reclosed records records record to the ensure that vision and electronic reclosed records | ontaining pertinent past<br>gs in accordance with                                                                                                                    | G 0236                                                                              | Administrator/designee will ensure that if agency changes electronic records vendor age has copies, either paper or electronic, of all patient record before changing vendor. (To begin immediately) Director of Nursing/designee vendors. | ncy<br>s             |  |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 105 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA                          |                              | (X2) MULTIPLE CONSTRUCTION |                                 |                                                                        | (X3) DATE SURVEY |  |
|-----------|-------------------------------------------------------------------------------|------------------------------|----------------------------|---------------------------------|------------------------------------------------------------------------|------------------|--|
| AND PLAN  | OF CORRECTION                                                                 | IDENTIFICATION NUMBER:       | A. BU                      | JILDING                         | 00                                                                     | COMPLETED        |  |
|           |                                                                               | 15K064                       | B. W                       | ING                             |                                                                        | 06/05/2017       |  |
|           |                                                                               |                              |                            | STREET A                        | ADDRESS, CITY, STATE, ZIP CODE                                         |                  |  |
| NAME OF P | PROVIDER OR SUPPLIEF                                                          | L                            |                            |                                 | 82ND ST STE 216                                                        |                  |  |
| АТ НОМІ   | E HEALTH SERVIC                                                               | EFSTIC                       |                            |                                 | APOLIS, IN 46250                                                       |                  |  |
|           |                                                                               |                              |                            |                                 | 711 0210, 114 10200                                                    |                  |  |
| (X4) ID   |                                                                               | TATEMENT OF DEFICIENCIES     |                            | ID                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE     | (X5)             |  |
| PREFIX    | ì ·                                                                           | CY MUST BE PRECEDED BY FULL  |                            | PREFIX                          | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                        |                  |  |
| TAG       |                                                                               | LSC IDENTIFYING INFORMATION) | +                          | TAG                             | instruct nurses to indicate on F                                       | DATE             |  |
|           | ^                                                                             | services in 1 out of 5       |                            |                                 | of Care the following: the corre                                       |                  |  |
|           |                                                                               | lucted (#2), failed to       |                            |                                 | address, status of others living                                       |                  |  |
|           | physician orders                                                              | were written for prn (as     |                            |                                 | the home, what tasks are to be                                         |                  |  |
|           | needed) visits ar                                                             | d that those prn skilled     |                            |                                 | provided by staff and                                                  |                  |  |
|           | nursing visits we                                                             | ere documented in 1 out      |                            |                                 | when(nursing/aide). (To be                                             |                  |  |
|           | of 4 records revi                                                             | ewed (#3) of patients        |                            |                                 | completed by 8/25/17)                                                  |                  |  |
|           |                                                                               | ing in a sample of 10;       |                            |                                 | Director of Nursing will be                                            | :I               |  |
|           |                                                                               | electronic medical           |                            |                                 | responsible to ensure newly hinurses are trained to indicate of        |                  |  |
|           |                                                                               | d an employee as a LPN       |                            |                                 | Plan of Care the following: the                                        |                  |  |
|           |                                                                               | 1 2 out of 2 records         |                            |                                 | correct address, status of othe                                        |                  |  |
|           |                                                                               |                              |                            |                                 | living in the home, what tasks                                         |                  |  |
|           |                                                                               | d 6) of patients receiving   |                            |                                 | to be provided by staff and wh                                         | en               |  |
|           |                                                                               | ervices from Employee E      |                            |                                 | (nursing/aide). (To be begin by                                        | /                |  |
|           | in a sample of 10                                                             | ); failed to ensure visit    |                            |                                 | 8/25/17)                                                               |                  |  |
|           | notes were comp                                                               | oleted and signed / dated    |                            |                                 | Director of Nursing/designee v                                         |                  |  |
|           | by the clinican in                                                            | n a timely manner in 1 of    |                            |                                 | audit, weekly, 100% of Plans of Care to monitor for compliance         |                  |  |
|           | 8 active records                                                              | reviewed (#4) in a           |                            |                                 | indicating the Plan of Care has                                        |                  |  |
|           |                                                                               | iled to ensure that the      |                            |                                 | the following: the correct addre                                       |                  |  |
|           | _                                                                             | the initial plan of care     |                            |                                 | status of others living in the                                         |                  |  |
|           | ` ' '                                                                         | imely manner in 1 out of     |                            |                                 | home, what tasks are to be                                             |                  |  |
|           |                                                                               | reviewed (#5) in a           |                            |                                 | provided by staff and when                                             |                  |  |
|           |                                                                               | ` '                          |                            |                                 | (nursing/aide). Once 100% compliance is achieved, Direct               | tor              |  |
|           | _                                                                             | d failed to evidence a       |                            |                                 | of Nursing/designee will audit                                         | .01              |  |
|           | _                                                                             | out of 8 active records      |                            |                                 | 25% of Plans of Care monthly                                           | to               |  |
|           | reviewed (#9) in                                                              | a sample of 10.              |                            |                                 | monitor for compliance. (To be                                         |                  |  |
|           |                                                                               |                              |                            |                                 | by 8/25/17)                                                            |                  |  |
|           | Findings include                                                              | :                            |                            |                                 | Director of Nursing/designee v                                         |                  |  |
|           |                                                                               |                              |                            |                                 | instruct nurses that a verbal or                                       |                  |  |
|           | 1. The clinical r                                                             | ecord for patient #1,        |                            |                                 | is needed from MD to make ex visits that fall outside the order        |                  |  |
|           |                                                                               | OC) 03/10/15, was            |                            |                                 | visits that fall outside the order visit frequency for that discipling |                  |  |
|           | `                                                                             | 31/17. The electronic        |                            |                                 | of the Plan of Care. (To be                                            |                  |  |
|           |                                                                               | ystem provided visit         |                            |                                 | completed by 8/25/17)                                                  |                  |  |
|           |                                                                               | - I                          |                            |                                 | Director of Nursing will be                                            |                  |  |
|           | dates and times but did not provide access to the actual visit notes. At 2:30 |                              |                            | responsible to ensure orientati |                                                                        |                  |  |
|           |                                                                               |                              |                            | of newly hired nurses includes  |                                                                        |                  |  |
|           |                                                                               | B, the Director of           |                            |                                 | training on needing a verbal or                                        |                  |  |
|           | Clinical Services                                                             | s, was requested to          |                            |                                 | from MD to make extra visits the                                       | าลเ              |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 106 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION   |       |             | (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
|------------------------------------------------------|---------------------|------------------------------|-------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION       | IDENTIFICATION NUMBER:       | A. BU | JILDING     | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | COMPLI | ETED       |
|                                                      |                     | 15K064                       | B. W  | B. WING 06. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 06/05/ | 2017       |
|                                                      |                     |                              |       | STREET A    | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
| NAME OF F                                            | ROVIDER OR SUPPLIER |                              |       |             | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
| ΛТ НОМІ                                              | E HEALTH SERVIC     | ESTIC                        |       |             | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
|                                                      | L HEALTH SERVIC     |                              |       | INDIAN      | AI OLIO, IN 40230                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
| (X4) ID                                              |                     | TATEMENT OF DEFICIENCIES     |       | ID          | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        | (X5)       |
| PREFIX                                               | · ·                 | CY MUST BE PRECEDED BY FULL  |       | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | TE     | COMPLETION |
| TAG                                                  |                     | LSC IDENTIFYING INFORMATION) | -     | TAG         | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        | DATE       |
|                                                      | provide home he     | ealth aide visit notes.      |       |             | fall outside the ordered visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
|                                                      |                     |                              |       |             | frequency for that discipline of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | tne    |            |
|                                                      | A. On 06/01         | 1/17 at 3:20 p.m.,           |       |             | Plan of Care. (To begin by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        |            |
|                                                      |                     | s requested again to         |       |             | Director of Nursing/designee v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | vill   |            |
|                                                      |                     | f home health aide visit     |       |             | track all nursing visits for a mo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      | notes.              | i nome nearm arec visit      |       |             | to monitor for compliance with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
|                                                      | notes.              |                              |       |             | following ordered frequency ar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | nd if  |            |
|                                                      | D 0 06/02           | N/17 + 11 50                 |       |             | extra visits are noted there is a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      |                     | 2/17 at 11:50 a.m.,          |       |             | verbal order for that visit. Once                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      | 1 2                 | provided a print out of      |       |             | 100% compliance is achieved,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |        |            |
|                                                      | home health aide    | e visits of recorded time    |       |             | Director of Nursing will track 2st of patients monthly to monitor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      | in and time out b   | etween 04/12/15 to           |       |             | compliance. (To begin by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 101    |            |
|                                                      | 06/12/15. Emplo     | oyee B indicated she was     |       |             | 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |            |
|                                                      | not able to provi   | de any information after     |       |             | The nurse who signed her                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |            |
|                                                      | 06/12/17.           | J                            |       |             | electronic notes as "RN" when                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        |            |
|                                                      | 00/12/1/.           |                              |       |             | she only had an Indiana licens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
|                                                      | C 0 0 06/06         | 5/17 at 0:45 a m             |       |             | was an oversight when putting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        |            |
|                                                      |                     | 5/17 at 9:45 a.m.,           |       |             | her credentials in the system.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ho     |            |
|                                                      | Employee A, the     |                              |       |             | That has been corrected and s is listed and signs as an "LPN.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        |            |
|                                                      |                     | as requested to provide      |       |             | She is an "RN" in Illinois and h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
|                                                      | patient #1 home     | health supervisory visit     |       |             | an "LPN" license in Indiana. Sl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | records. At 12:0    | 0 p.m., Employee A           |       |             | is working as an LPN for the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |        |            |
|                                                      | indicated the cor   | npany had changed            |       |             | agency and follows the Nurse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |        |            |
|                                                      | software and she    | was not able to obtain       |       |             | Practice Act standards for LPN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ١.     |            |
|                                                      | the visit notes an  | d would contact the          |       |             | She has not functioned in the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        |            |
|                                                      |                     | see if the agency would      |       |             | capacity of an RN while emplo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | yed    |            |
|                                                      |                     | oftware company to get       |       |             | by this agency. Director of Nursing is responsi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | hle    |            |
|                                                      |                     | record and obtain the        |       |             | for monitoring these corrective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      |                     | record and obtain the        |       |             | actions to ensure that this                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |            |
|                                                      | information.        |                              |       |             | deficiency is corrected and will                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | l      |            |
|                                                      |                     |                              |       |             | not recur.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        |            |
|                                                      | D. On 06/05         | 5/17 at 3:40 p.m.,           |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | Employee A was      | s only able to provide       |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | nursing visit reco  | ords 04/21, 04/23 -          |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | _                   | 60 - 06/17/15, 07/20 -       |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | 07/31/15, and 08    | ·                            |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      |                     |                              |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | Employee A ind      | icated she kept getting an   |       |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION (X |          |                                                                                        | X3) DATE SURVEY |            |
|-----------|------------------------------------------------------|------------------------------|-------------------------------|----------|----------------------------------------------------------------------------------------|-----------------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU                         | JILDING  | 00                                                                                     | COMPL           | ETED       |
|           |                                                      | 15K064                       | B. W                          | ING      |                                                                                        | 06/05/          | /2017      |
|           |                                                      |                              |                               | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                         |                 |            |
| NAME OF F | PROVIDER OR SUPPLIEF                                 | t .                          |                               |          | 82ND ST STE 216                                                                        |                 |            |
| АТ НОМ    | E HEALTH SERVIC                                      | CESTIC                       |                               |          | APOLIS, IN 46250                                                                       |                 |            |
|           |                                                      |                              |                               |          | 711 OE10, 11 <b>1</b> 40200                                                            |                 |            |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES     |                               | ID       | PROVIDER'S PLAN OF CORRECTION                                                          |                 | (X5)       |
| PREFIX    | `                                                    | CY MUST BE PRECEDED BY FULL  |                               | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE              | COMPLETION |
| TAG       |                                                      | LSC IDENTIFYING INFORMATION) |                               | TAG      | DEFICIENCE                                                                             |                 | DATE       |
|           |                                                      | not able to access the       |                               |          |                                                                                        |                 |            |
|           | home health aide                                     | e visit notes.               |                               |          |                                                                                        |                 |            |
|           |                                                      |                              |                               |          |                                                                                        |                 |            |
|           | 2. The clinical record for patient #2,               |                              |                               |          |                                                                                        |                 |            |
|           | SOC (start of car                                    | re) 03/06/12, was            |                               |          |                                                                                        |                 |            |
|           | reviewed on 6/2/                                     | 17. The plan of care         |                               |          |                                                                                        |                 |            |
|           |                                                      | er address where services    |                               |          |                                                                                        |                 |            |
|           | were initially pro                                   |                              |                               |          |                                                                                        |                 |            |
|           |                                                      |                              |                               |          |                                                                                        |                 |            |
|           | A A home                                             | visit on 6/1/17 at 9:00      |                               |          |                                                                                        |                 |            |
|           |                                                      | cted at the patient's        |                               |          |                                                                                        |                 |            |
|           |                                                      | where the patient had        |                               |          |                                                                                        |                 |            |
|           | ~                                                    | •                            |                               |          |                                                                                        |                 |            |
|           |                                                      | Ouring this time, the        |                               |          |                                                                                        |                 |            |
|           |                                                      | e indicated the patient use  |                               |          |                                                                                        |                 |            |
|           |                                                      | on but moved in with the     |                               |          |                                                                                        |                 |            |
|           | _                                                    | d been residing with the     |                               |          |                                                                                        |                 |            |
|           | daughter for a lo                                    | ong time and could not       |                               |          |                                                                                        |                 |            |
|           | remember when                                        | the patient had moved.       |                               |          |                                                                                        |                 |            |
|           | The plan of care                                     | failed to be updated with    |                               |          |                                                                                        |                 |            |
|           | accurate informa                                     | ation of the patient's       |                               |          |                                                                                        |                 |            |
|           | residence to whe                                     | ere services were to be      |                               |          |                                                                                        |                 |            |
|           | provided.                                            |                              |                               |          |                                                                                        |                 |            |
|           |                                                      |                              |                               |          |                                                                                        |                 |            |
|           | 3 The clinical r                                     | ecord for patient #3,        |                               |          |                                                                                        |                 |            |
|           |                                                      | vas reviewed on 5/31/17.     |                               |          |                                                                                        |                 |            |
|           | · ·                                                  | included orders for          |                               |          |                                                                                        |                 |            |
|           | _                                                    | very 14 days for             |                               |          |                                                                                        |                 |            |
|           | _                                                    |                              |                               |          |                                                                                        |                 |            |
|           | medication set u                                     | p.                           |                               |          |                                                                                        |                 |            |
|           |                                                      | /15 2 . 0 . 0                |                               |          |                                                                                        |                 |            |
|           |                                                      | /17 at 3:00 p.m.,            |                               |          |                                                                                        |                 |            |
|           |                                                      | Interim Assistant            |                               |          |                                                                                        |                 |            |
|           |                                                      | ical Services, indicated     |                               |          |                                                                                        |                 |            |
|           | she would make                                       | extra visits to the          |                               |          |                                                                                        |                 |            |
|           | natient's home to                                    | of ix the medication box     |                               |          |                                                                                        |                 |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 108 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                             | (X2) M                                 | ULTIPLE CO | NSTRUCTION   | (X3) DATE                                                              | SURVEY |            |
|------------------------------------------------------|---------------------------------------------|----------------------------------------|------------|--------------|------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                               | IDENTIFICATION NUMBER:                 | A. BU      | JILDING      | 00                                                                     | COMPL  | ETED       |
|                                                      |                                             | 15K064                                 | B. W       | B. WING 06/0 |                                                                        |        | 2017       |
|                                                      |                                             |                                        |            | STREET A     | ADDRESS, CITY, STATE, ZIP CODE                                         |        |            |
| NAME OF P                                            | ROVIDER OR SUPPLIER                         | ₹                                      |            |              | 82ND ST STE 216                                                        |        |            |
| ∧т ⊔∩Мі                                              | E HEALTH SERVIC                             | SES LLC                                |            |              | APOLIS, IN 46250                                                       |        |            |
| ATTIONI                                              |                                             |                                        |            | INDIAN       | AFOLIS, IN 40250                                                       |        |            |
| (X4) ID                                              | SUMMARY S                                   | TATEMENT OF DEFICIENCIES               |            | ID           | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX                                               | •                                           | ICY MUST BE PRECEDED BY FULL           |            | PREFIX       | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                  |                                             | LSC IDENTIFYING INFORMATION)           |            | TAG          | DEFICIENCY)                                                            |        | DATE       |
|                                                      | due to medicatio                            | ons not being refilled                 |            |              |                                                                        |        |            |
|                                                      | before her visit.                           | The clinical record                    |            |              |                                                                        |        |            |
|                                                      | failed to evidence physician orders and     |                                        |            |              |                                                                        |        |            |
|                                                      | visit notes for the extra visits made.      |                                        |            |              |                                                                        |        |            |
|                                                      |                                             | visit notes for the extra visits made. |            |              |                                                                        |        |            |
|                                                      | B On 5/31/                                  | B. On 5/31/17 at 4:10 p.m.,            |            |              |                                                                        |        |            |
|                                                      |                                             | _                                      |            |              |                                                                        |        |            |
|                                                      | Employee C indicated she was going to       |                                        |            |              |                                                                        |        |            |
|                                                      | -                                           | 's home that evening and               |            |              |                                                                        |        |            |
|                                                      | •                                           | atient had his / her                   |            |              |                                                                        |        |            |
|                                                      | medication for our home visit on $6/1/17$ . |                                        |            |              |                                                                        |        |            |
|                                                      |                                             |                                        |            |              |                                                                        |        |            |
|                                                      | C. On 6/2/17 at 4:45 p.m., Employee         |                                        |            |              |                                                                        |        |            |
|                                                      |                                             | did not obtain orders nor              |            |              |                                                                        |        |            |
|                                                      |                                             | e nursing visit notes.                 |            |              |                                                                        |        |            |
|                                                      | ara sne comprete                            | ridising visit notes.                  |            |              |                                                                        |        |            |
|                                                      | 4 The clinical r                            | record for patient #4 SOC              |            |              |                                                                        |        |            |
|                                                      |                                             | riewed. The skilled                    |            |              |                                                                        |        |            |
|                                                      |                                             |                                        |            |              |                                                                        |        |            |
|                                                      | nursing visit not                           | es indicated the                       |            |              |                                                                        |        |            |
|                                                      | following:                                  |                                        |            |              |                                                                        |        |            |
|                                                      |                                             |                                        |            |              |                                                                        |        |            |
|                                                      | A. A visit n                                | ote on 5/26/17, was                    |            |              |                                                                        |        |            |
|                                                      | provided on 6/2/                            | 17. The visit note was                 |            |              |                                                                        |        |            |
|                                                      | incomplete and f                            | failed to include                      |            |              |                                                                        |        |            |
|                                                      | cardiovascular, g                           |                                        |            |              |                                                                        |        |            |
|                                                      | neurological / m                            | •                                      |            |              |                                                                        |        |            |
|                                                      | -                                           |                                        |            |              |                                                                        |        |            |
|                                                      | genitourinary, pu                           | •                                      |            |              |                                                                        |        |            |
|                                                      | musculoskeletal,                            |                                        |            |              |                                                                        |        |            |
|                                                      | assessments, into                           | -                                      |            |              |                                                                        |        |            |
|                                                      | professional serv                           | vices provided. The note               |            |              |                                                                        |        |            |
|                                                      | also failed to inc                          | lude a signature with                  |            |              |                                                                        |        |            |
|                                                      | date.                                       | -                                      |            |              |                                                                        |        |            |
|                                                      |                                             |                                        |            |              |                                                                        |        |            |
|                                                      | R On 6/5/1                                  | 7, the agency provided                 |            |              |                                                                        |        |            |
|                                                      |                                             |                                        |            |              |                                                                        |        |            |
|                                                      | i anomei visit not                          | e dated 5/26/17 that                   | - 1        |              |                                                                        |        | I          |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED                |                         |        |                                                                 |        |            |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------|--------|-----------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                 | IDENTIFICATION NUMBER:                                                              | A. BUILDING 00  B. WING |        |                                                                 |        |            |
|                                                      |                                                                                                                                                                                               | 15K064                                                                              | D. W                    | _      |                                                                 | 06/05/ | 2017       |
| NAME OF P                                            | PROVIDER OR SUPPLIER                                                                                                                                                                          |                                                                                     |                         |        | ADDRESS, CITY, STATE, ZIP CODE                                  |        |            |
| AT HOMI                                              | E HEALTH SERVIC                                                                                                                                                                               | ES LLC                                                                              |                         |        | 82ND ST STE 216<br>APOLIS, IN 46250                             |        |            |
| (X4) ID                                              |                                                                                                                                                                                               | TATEMENT OF DEFICIENCIES                                                            | 1                       | ID     |                                                                 | 1      | (X5)       |
| PREFIX                                               |                                                                                                                                                                                               | CY MUST BE PRECEDED BY FULL                                                         |                         | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | -      | COMPLETION |
| TAG                                                  | REGULATORY OR                                                                                                                                                                                 | LSC IDENTIFYING INFORMATION)                                                        |                         | TAG    | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)                  | _      | DATE       |
|                                                      | evidenced an ass                                                                                                                                                                              | essment of the                                                                      |                         |        |                                                                 |        |            |
|                                                      | cardiovascular, g                                                                                                                                                                             | gastrointestinal,                                                                   |                         |        |                                                                 |        |            |
|                                                      | neurological / mental status,                                                                                                                                                                 |                                                                                     |                         |        |                                                                 |        |            |
|                                                      | genitourinary, pu                                                                                                                                                                             | ılmonary,                                                                           |                         |        |                                                                 |        |            |
|                                                      | musculoskeletal,                                                                                                                                                                              | integumentary systems                                                               |                         |        |                                                                 |        |            |
|                                                      |                                                                                                                                                                                               | lence a pain assessment,                                                            |                         |        |                                                                 |        |            |
|                                                      |                                                                                                                                                                                               | d professional services                                                             |                         |        |                                                                 |        |            |
|                                                      | *                                                                                                                                                                                             | e top of the visit note, it                                                         |                         |        |                                                                 |        |            |
|                                                      | is indicated that                                                                                                                                                                             | the LPN signed the visit                                                            |                         |        |                                                                 |        |            |
|                                                      | note on 6/4/17 and at the bottom of the                                                                                                                                                       |                                                                                     |                         |        |                                                                 |        |            |
|                                                      | page, the note indicated the LPN signed                                                                                                                                                       |                                                                                     |                         |        |                                                                 |        |            |
|                                                      | the visit note on                                                                                                                                                                             | 5/26/17.                                                                            |                         |        |                                                                 |        |            |
|                                                      | nursing visit note 5/9, 5/15, 5/16, 5/6/2/17, indicated completed by En Nurse but the last were electronical E, a Licensed Proceeding The Licensing websit indicated that En only. The only F | nployee E, a Registered st page of the visit notes lly signed by Employee           |                         |        |                                                                 |        |            |
|                                                      | Administrator, and Director of Clini intereviewed on                                                                                                                                          | Employee A, the Alternate nd Employee B, the cal Services, were 6/5/17 at 3:45 p.m. |                         |        |                                                                 |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 110 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                         | (X2) M                       | (X2) MULTIPLE CONSTRUCTION |          |                                                                     | SURVEY |            |
|------------------------------------------------------|-----------------------------------------|------------------------------|----------------------------|----------|---------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                           | IDENTIFICATION NUMBER:       | A. BU                      | JILDING  | 00                                                                  | COMPL  | ETED       |
|                                                      |                                         | 15K064                       | B. W                       | ING      |                                                                     | 06/05/ | /2017      |
|                                                      |                                         |                              |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                      |        |            |
| NAME OF P                                            | PROVIDER OR SUPPLIEF                    | ₹                            |                            |          | 82ND ST STE 216                                                     |        |            |
| ΛΤ ⊔ΩΜΙ                                              | E HEALTH SERVIC                         | SES LLC                      |                            |          | APOLIS, IN 46250                                                    |        |            |
| ATTIONI                                              | E HEALTH SERVIC                         | ,E3 LLC                      |                            | INDIAN   | AFOLIS, IN 40250                                                    |        |            |
| (X4) ID                                              |                                         | TATEMENT OF DEFICIENCIES     |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                               | `                                       | ICY MUST BE PRECEDED BY FULL |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE    | COMPLETION |
| TAG                                                  | REGULATORY OR                           | LSC IDENTIFYING INFORMATION) |                            | TAG      | DEFICIENCY)                                                         |        | DATE       |
|                                                      | discrepancy was                         | a computor error and         |                            |          |                                                                     |        |            |
|                                                      | that Employee E                         | E worked for a local         |                            |          |                                                                     |        |            |
|                                                      | hospital with his / her RN license and  |                              |                            |          |                                                                     |        |            |
|                                                      | worked for the h                        | nome health agency under     |                            |          |                                                                     |        |            |
|                                                      |                                         | ense due to a contract       |                            |          |                                                                     |        |            |
|                                                      | with the hospital                       |                              |                            |          |                                                                     |        |            |
|                                                      | with the nospital                       |                              |                            |          |                                                                     |        |            |
|                                                      | 5 The clinical r                        | record for patient #5 SOC    |                            |          |                                                                     |        |            |
|                                                      |                                         | eviewed. The initial plan    |                            |          |                                                                     |        |            |
|                                                      | •                                       | •                            |                            |          |                                                                     |        |            |
|                                                      | of care dated 11/21/16 to 1/20/17,      |                              |                            |          |                                                                     |        |            |
|                                                      | evidenced that the physician signed the |                              |                            |          |                                                                     |        |            |
|                                                      | plan of care on 1                       | 1/13/17. The agency          |                            |          |                                                                     |        |            |
|                                                      | failed to ensure t                      | that the physician signed    |                            |          |                                                                     |        |            |
|                                                      | the initial plan o                      | f care orders within a       |                            |          |                                                                     |        |            |
|                                                      | timely manner.                          |                              |                            |          |                                                                     |        |            |
|                                                      |                                         |                              |                            |          |                                                                     |        |            |
|                                                      | 6. The clinical r                       | record for patient #6,       |                            |          |                                                                     |        |            |
|                                                      | SOC 1/30/17, w                          | •                            |                            |          |                                                                     |        |            |
|                                                      |                                         | , was 10 110 W.Cu.           |                            |          |                                                                     |        |            |
|                                                      | A Skilled r                             | nursing visit notes dated    |                            |          |                                                                     |        |            |
|                                                      |                                         | · ·                          |                            |          |                                                                     |        |            |
|                                                      |                                         | , 4/24, 5/1 and 5/17/17,     |                            |          |                                                                     |        |            |
|                                                      |                                         | tes were completed by        |                            |          |                                                                     |        |            |
|                                                      |                                         | Registered Nurse but the     |                            |          |                                                                     |        |            |
|                                                      | visit notes were                        | electronically signed by     |                            |          |                                                                     |        |            |
|                                                      | Employee E, a L                         | Licensed Practical Nurse.    |                            |          |                                                                     |        |            |
|                                                      |                                         |                              |                            |          |                                                                     |        |            |
|                                                      | 1. The 1                                | Indiana Professional         |                            |          |                                                                     |        |            |
|                                                      | Licensing websi                         | te was reviewed and          |                            |          |                                                                     |        |            |
|                                                      |                                         | nployee E was a LPN          |                            |          |                                                                     |        |            |
|                                                      |                                         | Registered Nurses with       |                            |          |                                                                     |        |            |
|                                                      |                                         |                              |                            |          |                                                                     |        |            |
|                                                      |                                         | ne were licensed in          |                            |          |                                                                     |        |            |
|                                                      | Illinois.                               |                              |                            |          |                                                                     |        |            |
|                                                      |                                         |                              |                            |          |                                                                     |        |            |
|                                                      | 2. The                                  | Alternate Administrator      |                            |          |                                                                     |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 111 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CC A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                          | OO 00                                                                                     | COMPI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |  |  |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|--|--|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRODE TO THE APPROPRIES OF THE | D BE                                  | (X5)<br>COMPLETION<br>DATE |  |  |
|                                                                                                            | intereviewed on they indicated the computor error as worked for a loc RN license and health agency undue to a contract agency did not with truly a registered.  7. The clinical responsible so the current certification orders the current certification of the current certificatio | Clinical Services were 6/5/17 at 3:45 p.m., and at the discrepancy was a and that Employee E al hospital with his / her worked for the home oder his / her LPN license with the hospital. The verify if Employee E was a nurse.  The verify if Employee E was a nurse.  The verify if Employee E was and the plan of care for and the plan of care for and the plan of care for and again on not failed to evidence sician orders and plan of |                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                            |  |  |
|                                                                                                            | Services and Em<br>Assistant Direct<br>had no further in<br>documentation i<br>findings on 6/2/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | n relation to the above 17 at 4:00 p.m.                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                            |  |  |
|                                                                                                            | further informat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A, the Alternate and Employee B, had no ion or documentation by ace on 6/5/17 at 3:50 p.m.                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                            |  |  |
| G 0237                                                                                                     | 484.48(a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                            |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 112 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |          | SURVEY                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |            |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------|
| AND PLAN (                                           | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. BU    | A. BUILDING <u>00</u> COMPL |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ETED                          |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | B. WI    | NG                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 06/05/                        | 2017       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <u> </u> | STREET A                    | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               |            |
| NAME OF P                                            | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |                             | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |            |
| AT HOME                                              | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |          |                             | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |            |
| (X4) ID                                              | SUMMARY ST                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |          | ID                          | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | (X5)       |
| PREFIX                                               | *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          | PREFIX                      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ΓE                            | COMPLETION |
| TAG                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          | TAG                         | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               | DATE       |
| Bldg. 00                                             | the month the cost records apply is filt unless State law stime. Policies provide HHA disconting Based on record the agency failed contents of a patterained and accereviewed in a sar Findings include  1. The clinical restricted on 05/3 medical record states and times be access to the actup.m., Employee 1 Clinical Services provide home he  2. On 06/01/17 a was requested aghome health aided  3. On 06/02/17 a B provided a print aide visits of record out between 04/1 | e retained for 5 years after threport to which the ed with the intermediary, tipulates a longer period of vide for retention even if use operations.  review and interview, to ensure that all the itent's clinical record was essible in 1 of 1 record emple of 10. (#1)  :  ecord for patient # 1, DC) 03/10/15, was 81/17. The electronic eystem provided visit but did not provide enal visit notes. At 2:30 B, the Director of each was requested to alth aide visit notes.  at 3:20 p.m., Employee B gain to provide copies of | G 02     | 237                         | Administrator/designee will ensure that if agency changes electronic records vendor ager has copies, either paper or electronic, of all patient record before changing vendor. (To b done by 8/25/2017) Director of Nursing/designee wensure there is someone available, in office or by phone who can assist with computer issues when staff is unable to access patient electronic record There will be a list posted in office, in a central location, indicating who to contact and it to contact them. During staff meetings Director of Nursing/designee will remind sof who to contact when having issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17) | ncy<br>s<br>e<br>vill<br>rds. | 08/25/2017 |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                           | A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                              | ONSTRUCTION  00                                                                     | COMPLETED 06/05/2017                                                                                                                             |                      |  |  |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--|--|
|                                                       | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                  |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                            | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                            | (X5) COMPLETION DATE |  |  |
|                                                       | A, the Alternate requested to provide health supervisor 12:00 p.m., Employment and the was not able to do would contact the agency would software comparrecord and obtain 5. On 06/05/17 A was only able records 04/21, 04/06/17/15, 07/20 08/19/15. Employment in the agency would software comparrecord and obtain 5. On 06/05/17 A was only able records 04/21, 04/06/17/15, 07/20 08/19/15. Employment in the agency would be recorded and obtain 15. | at 9:45 a.m., Employee Administrator, was yide patient #1 home ry visit records. At loyee A indicated the anged software and she betain the visit notes and e Administrator to see if d pay the former ry to get into the clinical in the information.  at 3:40 p.m., Employee to provide nursing visit 4/23 -4/28/15 and 06/30 07/31/15, and 08/18 - royee A indicated she error" and was not able ine health aide visit notes. |                                                                                     |                                                                                                                                                  |                      |  |  |
| G 0250<br>Bldg. 00                                    | professionals, represcope of the progrescope of the progrescope of the progrescope of the progrescope of the agency failed quarterly meeting.                                                                                                                                                                                                                                                                                                             | appropriate health resenting at least the am, review a sample of osed clinical records to r established policies are ing services directly or it. review and interview,                                                                                                                                                                                                                                                          | G 0250                                                                              | Administrator and Director of Nursing/designee will be responsible to ensure quarter QAPI is done. Director of Nur will be responsible to obtain | •                    |  |  |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           | UILDING  | 00                  | (X3) DATE<br>COMPL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                         |                            |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------|
|                                               |                                                                                                                                                                                                                                                                                                       | 15K064                                                                                                                                                                                                                                                                                                    | B. W     | ING                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 06/05/                                  | /2017                      |
|                                               | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                           | <u> </u> | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN                                                                                                                                                                                                                                                                                        | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                         |          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ιΤΕ                                     | (X5)<br>COMPLETION<br>DATE |
|                                               | closed records to established policin furnishing ser. Findings include  1. On 6/5/17 at 2 (Quality Assurar Improvement) previewed. During the Alternate Add that there was not but provided concreview of the againdicated they disinformation from implemented that program. Employeensultant wanted | 2:00 p.m., the QAPI nce Performance rogram was asked to be g this time, Employee A, ministrator, indicated at a 2017 QAPI to review asultant notes of their ency. Employee A d not take the a the consultant and t into their QAPI byee A indicated the ad to wait until the end of July before coming to |          |                     | information required for QAPI write the report. Director of Nursing will be responsible to notify those needing to attend the meeting date and time, ha materials avail for review duri meeting, having sign in sheet keeping meeting minutes, whi will include: what was discuss what is the plan to address issues, who will monitor and with goals are for each issue. (be done by 8/25/17) Administrator and Director of Nursing will be responsible to ensure any reports, reviews, audits, etc. that are done by a outside entity that are pertinenthe QAPI requirements are included in the quarterly report The material to presented will reviewed prior to meeting to ensure they contain all require information. (To be done by 8/25/17) | of ving ng ch ed, vhat To n nt to t. be |                            |
| G 0330<br>Bldg. 00                            | PATIENTS Each patient must must provide, a pa comprehensive as reflects the patien and includes infort to demonstrate the achievement of de comprehensive as                                                                                                                                          | receive, and an HHA atient-specific, seessment that accurately t's current health status mation that may be used e patient's progress toward esired outcomes. The seessment must identify nuing need for home care                                                                                        |          |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 115 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                            |                                                        | ULTIPLE CC<br>JILDING | 00       | (X3) DATE<br>COMPL                                                                    |       |            |
|-----------------------------------------------|--------------------------------------------|--------------------------------------------------------|-----------------------|----------|---------------------------------------------------------------------------------------|-------|------------|
|                                               |                                            | 15K064                                                 | B. W                  | ING      |                                                                                       | 06/05 |            |
|                                               |                                            |                                                        | <u> </u>              | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                        |       |            |
| NAME OF I                                     | PROVIDER OR SUPPLIEF                       | (                                                      |                       | 6525 E   | 82ND ST STE 216                                                                       |       |            |
| AT HOM                                        | E HEALTH SERVIC                            | CES LLC                                                |                       | INDIAN   | APOLIS, IN 46250                                                                      |       |            |
| (X4) ID                                       |                                            | TATEMENT OF DEFICIENCIES                               |                       | ID       | PROVIDER'S PLAN OF CORRECTION                                                         |       | (X5)       |
| PREFIX                                        |                                            | ICY MUST BE PRECEDED BY FULL                           |                       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE    | COMPLETION |
| TAG                                           |                                            | ent's medical, nursing,                                |                       | TAG      | DEFICIENCT)                                                                           |       | DATE       |
|                                               | I                                          | ial, and discharge planning                            |                       |          |                                                                                       |       |            |
|                                               | needs. For Medic                           | care beneficiaries, the HHA                            |                       |          |                                                                                       |       |            |
|                                               |                                            | tient's eligibility for the                            |                       |          |                                                                                       |       |            |
|                                               |                                            | ealth benefit including s, both at the time of the     |                       |          |                                                                                       |       |            |
|                                               |                                            | visit and at the time of the                           |                       |          |                                                                                       |       |            |
|                                               | comprehensive as                           |                                                        |                       |          |                                                                                       |       |            |
|                                               |                                            | ssessment must also                                    |                       |          |                                                                                       |       |            |
|                                               |                                            | se of the current version of<br>Assessment Information |                       |          |                                                                                       |       |            |
|                                               |                                            | s, using the language and                              |                       |          |                                                                                       |       |            |
|                                               | groupings of the OASIS items, as specified |                                                        |                       |          |                                                                                       |       |            |
|                                               | by the Secretary                           |                                                        |                       | •••      | 0 0000 0004 0007 0006                                                                 |       |            |
|                                               |                                            | review and interview,                                  | G 0                   | 330      | See G332, G334, G337, G339                                                            | ,     | 08/25/2017 |
|                                               | "                                          | d to ensure that a                                     |                       |          |                                                                                       |       |            |
|                                               |                                            | e conducted an initial                                 |                       |          |                                                                                       |       |            |
|                                               |                                            | in order to determine the                              |                       |          |                                                                                       |       |            |
|                                               |                                            | s of patients in 7 of 8                                |                       |          |                                                                                       |       |            |
|                                               |                                            | d of patients admitted                                 |                       |          |                                                                                       |       |            |
|                                               |                                            | sample of 10 (See G                                    |                       |          |                                                                                       |       |            |
|                                               | 1                                          | nsure that the Registered                              |                       |          |                                                                                       |       |            |
|                                               | _                                          | nsive assessment was                                   |                       |          |                                                                                       |       |            |
|                                               | -                                          | cluded skin assessments                                |                       |          |                                                                                       |       |            |
|                                               | _                                          | nd urostomy sites, diet                                |                       |          |                                                                                       |       |            |
|                                               | · ·                                        | led to completely assess                               |                       |          |                                                                                       |       |            |
|                                               |                                            | nd respiratory system in                               |                       |          |                                                                                       |       |            |
|                                               |                                            | ls reviewed of patients                                |                       |          |                                                                                       |       |            |
|                                               |                                            | sing services in a sample                              |                       |          |                                                                                       |       |            |
|                                               | ` / /                                      | ailed to ensure that the                               |                       |          |                                                                                       |       |            |
|                                               | 1                                          | tle was updated upon orders in 1 out of 8              |                       |          |                                                                                       |       |            |
|                                               |                                            |                                                        |                       |          |                                                                                       |       |            |
|                                               |                                            | eviewed in a sample of 10 ure the medication           |                       |          |                                                                                       |       |            |
|                                               |                                            |                                                        |                       |          |                                                                                       |       |            |
|                                               | profile include c                          |                                                        |                       |          |                                                                                       |       |            |
|                                               | physician, phone                           |                                                        |                       |          |                                                                                       |       |            |
|                                               | pnysician and pr                           | narmacy, purpose of                                    |                       |          |                                                                                       |       |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 116 of 247

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                    | A. BUILDING  B. WING                                                                                                                                        | 00                  | COMPLETED 06/05/2017                                                                                                    |                      |
|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------|
| NAME OF P                                             | ROVIDER OR SUPPLIER                                                                                                                                                                                |                                                                                                                                                             |                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                       |                      |
|                                                       | HEALTH SERVIC                                                                                                                                                                                      |                                                                                                                                                             |                     | APOLIS, IN 46250                                                                                                        |                      |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC                                                                                                                                                                                    | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                       | 3 out of 8 active sample of 10 (Se ensure that the R conducted a com 2 of 2 active recopatient receiving a Medicare agency G 339); and faile Registered Nurse assessment based visit in 1 of 2 dis | plete skin assessment in ords reviewed of a wound treatments with cy in a sample of 10 (See d to ensure the completed a discharge d on last skilled nursing |                     |                                                                                                                         |                      |
|                                                       | problem resulted<br>of compliance with<br>Participation 484<br>Assessments.                                                                                                                        | effect of this systemic in the agency being out ith the Condition of 5.55: Comprehensive                                                                    |                     |                                                                                                                         |                      |
|                                                       | problems resulted                                                                                                                                                                                  | d in the home health to ensure the provision                                                                                                                |                     |                                                                                                                         |                      |
| G 0332                                                | 484.55(a)(1)<br>INITIAL ASSESSN                                                                                                                                                                    | MENT VISIT                                                                                                                                                  |                     |                                                                                                                         |                      |
| Bldg. 00                                              | The initial assessn<br>either within 48 ho<br>hours of the patien<br>physician-ordered                                                                                                             | nent visit must be held<br>urs of referral, or within 48<br>nt's return home, or on the<br>start of care date.                                              | G 0202              | Director of Nursing /decimes                                                                                            | ill 00/25/2017       |
|                                                       | Based on record                                                                                                                                                                                    | review and interview,                                                                                                                                       | G 0332              | Director of Nursing/designee w in-service staff on requirement                                                          |                      |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 117 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                            | (X2) MULTIPLE CONSTRUCTION   |       | (X3) DATE SURVEY |                                                                        |               |            |
|------------------------------------------------------|--------------------------------------------|------------------------------|-------|------------------|------------------------------------------------------------------------|---------------|------------|
| AND PLAN                                             | OF CORRECTION                              | IDENTIFICATION NUMBER:       | A. BU | JILDING          | 00                                                                     | COMPL         | ETED       |
|                                                      |                                            | 15K064                       | B. W  | ING              |                                                                        | 06/05/        | 2017       |
|                                                      |                                            |                              |       | OTD FET A        | ADDRESS CITY STATE ZIR CODE                                            |               |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                       | 2                            |       |                  | ADDRESS, CITY, STATE, ZIP CODE                                         |               |            |
| 4.7.1.014                                            |                                            | NEO 11 O                     |       |                  | 82ND ST STE 216                                                        |               |            |
| AT HOM                                               | E HEALTH SERVIC                            | ESTLC                        |       | INDIAN           | APOLIS, IN 46250                                                       |               |            |
| (X4) ID                                              | SUMMARY S                                  | TATEMENT OF DEFICIENCIES     |       | ID               | PROVIDER'S PLAN OF CORRECTION                                          |               | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                             | CY MUST BE PRECEDED BY FULL  |       | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TF.           | COMPLETION |
| TAG                                                  | REGULATORY OR                              | LSC IDENTIFYING INFORMATION) |       | TAG              | DEFICIENCY)                                                            |               | DATE       |
|                                                      | the agency failed                          | d to ensure that a           |       |                  | make initial assessment of pat                                         | ient          |            |
|                                                      | Registered Nurse conducted an initial      |                              |       |                  | within forty-eight (48) hours of                                       |               |            |
|                                                      | assessment visit in order to determine the |                              |       |                  | receiving referral. If initial                                         |               |            |
|                                                      |                                            |                              |       |                  | evaluation visit cannot be mad                                         | е             |            |
|                                                      |                                            | s of patients in 7 of 8      |       |                  | within forty-eight hours, there                                        |               |            |
|                                                      |                                            | d of patients admitted       |       |                  | must be documentation to                                               |               |            |
|                                                      | since 2015 in a s                          | sample of 10. (# 1, 3, 4,    |       |                  | support why not made (needs                                            |               |            |
|                                                      | 5, 6, 8, 9)                                |                              |       |                  | be patient's choice) and must made as soon as possible.                | be            |            |
|                                                      |                                            |                              |       |                  | Director of Nursing will implem                                        | ent           |            |
|                                                      | Findings include                           | ••                           |       |                  | a process ensuring nurses are                                          |               |            |
|                                                      | i manigs merade                            | ·•                           |       |                  | notified of referral immediately                                       |               |            |
|                                                      |                                            |                              |       |                  | an order can be obtained to m                                          |               |            |
|                                                      | 1. The clinical record for patient #1,     |                              |       |                  | evaluation visit to assess patie                                       | nt            |            |
|                                                      | Start of Care (SO                          | OC) 03/10/15, was            |       |                  | for appropriateness of home                                            |               |            |
|                                                      | reviewed and fai                           | led to evidence an initial   |       |                  | health care needs and eligibilit                                       | y. If         |            |
|                                                      | assessment visit                           | note.                        |       |                  | it is determined patient is not                                        |               |            |
|                                                      |                                            |                              |       |                  | appropriate for home health ca                                         | are           |            |
|                                                      | 2 The clinical r                           | ecord for patient #3,        |       |                  | or they refuse services, nurse                                         |               |            |
|                                                      |                                            |                              |       |                  | must notify MD of this and                                             |               |            |
|                                                      | · ·                                        | vas reviewed. The            |       |                  | document on paperwork. (To be done by 8/25/17)                         | e             |            |
|                                                      |                                            | ncluded a referral form      |       |                  | Director of Nursing will be                                            |               |            |
|                                                      | dated 9/19/16. T                           | The clinical record failed   |       |                  | responsible to ensure orientati                                        | on            |            |
|                                                      | to evidence an ir                          | nitial assessment visit      |       |                  | of newly hired nurses includes                                         |               |            |
|                                                      | note within 48 h                           | ours of the referral.        |       |                  | training on requirement to make                                        |               |            |
|                                                      |                                            |                              |       |                  | initial assessment of patient                                          |               |            |
|                                                      | 2 The clinical r                           | ecord for patient #4,        |       |                  | within forty-eight (48) hours of                                       |               |            |
|                                                      |                                            | *                            |       |                  | receiving referral. If initial                                         |               |            |
|                                                      |                                            | as reviewed. The clinical    |       |                  | evaluation visit cannot be mad                                         | е             |            |
|                                                      |                                            | a referral form dated        |       |                  | within forty-eight hours, there                                        |               |            |
|                                                      | 3/15/17. The cli                           | nical record failed to       |       |                  | must be documentation to                                               | <sub>+0</sub> |            |
|                                                      | evidence an initi                          | al assessment visit note     |       |                  | support why not made (needs                                            |               |            |
|                                                      | within 48 hours                            | of the referral.             |       |                  | be patient's choice) and must made as soon as possible.                | be            |            |
|                                                      |                                            |                              |       |                  | Director of Nursing will implem                                        | ent           |            |
|                                                      | 4 The clinical m                           | good for nationt #5          |       |                  | a process ensuring nurses are                                          |               |            |
|                                                      |                                            | ecord for patient #5,        |       |                  | notified of referral immediately                                       |               |            |
|                                                      | · ·                                        | vas reviewed. The            |       |                  | an order can be obtained to m                                          |               |            |
|                                                      |                                            | ncluded a referral form      |       |                  | evaluation visit to assess patie                                       | nt            |            |
|                                                      | dated 11/15/16.                            | The clinical record          |       |                  | for appropriateness of home                                            |               |            |
|                                                      | failed to evidence                         | e an initial assessment      |       |                  | health care needs and eligibilit                                       | y. If         |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                   | (X2) M                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI |                          |                                                                                       |            |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------|--------------------------|---------------------------------------------------------------------------------------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                     | IDENTIFICATION NUMBER:       | A. BU                                      | A. BUILDING 00 COMPLETED |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | 15K064                       | B. W                                       | ING                      |                                                                                       | 06/05/2017 |
| NAME OF I                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                              |                              |                                            | STREET A                 | ADDRESS, CITY, STATE, ZIP CODE                                                        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                              |                              |                                            | 6525 E                   | 82ND ST STE 216                                                                       |            |
| AT HOM                                               | E HEALTH SERVIC                                                                                                                                                                                                                                   | CES LLC                      |                                            | INDIAN                   | APOLIS, IN 46250                                                                      |            |
| (X4) ID                                              |                                                                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES     |                                            | ID                       | PROVIDER'S PLAN OF CORRECTION                                                         | (X5)       |
| PREFIX                                               | ,                                                                                                                                                                                                                                                 | ICY MUST BE PRECEDED BY FULL |                                            | PREFIX                   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |            |
| TAG                                                  |                                                                                                                                                                                                                                                   | LSC IDENTIFYING INFORMATION) |                                            | TAG                      | it is determined patient is not                                                       | DATE       |
|                                                      | visit note within                                                                                                                                                                                                                                 | 48 hours of the referral.    |                                            |                          | appropriate for home health ca                                                        | are        |
|                                                      | 5 m 1: 1                                                                                                                                                                                                                                          | 1.6                          |                                            |                          | or they refuse services, nurse                                                        |            |
|                                                      |                                                                                                                                                                                                                                                   | record for patient #6,       |                                            |                          | must notify MD of this and                                                            |            |
|                                                      | SOC 1/30/17, was reviewed. The clinical                                                                                                                                                                                                           |                              |                                            |                          | document on paperwork. (To                                                            | be         |
|                                                      | record failed to evidence a referral form                                                                                                                                                                                                         |                              |                                            |                          | done by 8/25/17)                                                                      | ,          |
|                                                      | <ul> <li>and / or a coordination note which indicated when the patient would be discharged from the hospital. The clinical record failed to evidence an initial assessment visit note.</li> <li>6. The clinical record for patient #8,</li> </ul> |                              |                                            |                          | Director of Nursing/designee will be notified of all referrals                        |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | immediately. Director/designee                                                        |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | will be responsible to track                                                          |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | referrals to monitor for                                                              |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | compliance with making initial                                                        |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | assessment visit within time                                                          |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | frame or if it was determined                                                         |            |
|                                                      |                                                                                                                                                                                                                                                   | s reviewed. The clinical     |                                            |                          | patient was not eligible for home                                                     | e          |
|                                                      |                                                                                                                                                                                                                                                   | a referral form dated        |                                            |                          | care referral source/MD is                                                            |            |
|                                                      |                                                                                                                                                                                                                                                   | inical record failed to      |                                            |                          | notified. Director will be                                                            |            |
|                                                      |                                                                                                                                                                                                                                                   | al assessment visit note     |                                            |                          | responsible to monitor for                                                            |            |
|                                                      | within 48 hours                                                                                                                                                                                                                                   | of the referral.             |                                            |                          | compliance with initial                                                               |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          | assessment visit being done                                                           |            |
|                                                      |                                                                                                                                                                                                                                                   | record for patient #9,       |                                            |                          | within forty-eight (48) hours.                                                        |            |
|                                                      | · ·                                                                                                                                                                                                                                               | s reviewed. The clinical     |                                            |                          | This will be done by comparing                                                        |            |
|                                                      |                                                                                                                                                                                                                                                   | a referral form dated        |                                            |                          | date of referral to date on initial                                                   |            |
|                                                      |                                                                                                                                                                                                                                                   | ical record failed to        |                                            |                          | assessment visit. (To begin by                                                        |            |
|                                                      |                                                                                                                                                                                                                                                   | al assessment visit note     |                                            |                          | 8/25/17                                                                               |            |
|                                                      | within 48 hours                                                                                                                                                                                                                                   | of the referral.             |                                            |                          |                                                                                       |            |
|                                                      | 8 During the er                                                                                                                                                                                                                                   | ntrance conference with      |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | , the Interim Assistant      |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | ical Services and with       |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | e Alternate Administrator    |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | :10 a.m. Employee A          |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | eir referral process         |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   | , verify insurance or        |                                            |                          |                                                                                       |            |
|                                                      |                                                                                                                                                                                                                                                   |                              |                                            |                          |                                                                                       |            |
|                                                      | _                                                                                                                                                                                                                                                 | norization with Medicaid,    |                                            |                          |                                                                                       |            |
|                                                      | once prior authorization obtained, orders                                                                                                                                                                                                         |                              |                                            |                          |                                                                                       |            |

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | î ´                                                       | LTIPLE CO<br>LDING | 00            | (X3) DATE :<br>COMPL                                               |        |                    |
|------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------------|--------------------|---------------|--------------------------------------------------------------------|--------|--------------------|
|                                                                                                      |                      | 15K064                                                    | B. WIN             | IG            |                                                                    | 06/05/ | 2017               |
| NAME OF B                                                                                            | PROVIDER OR SUPPLIER | <u> </u>                                                  | <u> </u>           | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
|                                                                                                      |                      |                                                           |                    |               | 82ND ST STE 216                                                    |        |                    |
|                                                                                                      | E HEALTH SERVIC      | ES LLC                                                    |                    | INDIAN        | APOLIS, IN 46250                                                   |        |                    |
| (X4) ID<br>PREFIX                                                                                    |                      | TATEMENT OF DEFICIENCIES                                  |                    | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| TAG                                                                                                  | ``                   | CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) | ľ                  | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)                  | ΓE     | COMPLETION<br>DATE |
|                                                                                                      | obtained from pl     | nysician for admission,                                   |                    |               |                                                                    |        |                    |
|                                                                                                      | •                    | would be admitted.                                        |                    |               |                                                                    |        |                    |
|                                                                                                      | Employee A indi      | icated that patients were                                 |                    |               |                                                                    |        |                    |
|                                                                                                      | not assessed with    | nin 48 hours of referral.                                 |                    |               |                                                                    |        |                    |
|                                                                                                      | Employee C indi      | icated the 48 hour initial                                |                    |               |                                                                    |        |                    |
|                                                                                                      | assessment made      | e sense and indicated                                     |                    |               |                                                                    |        |                    |
|                                                                                                      | even when order      | s are obtained, that                                      |                    |               |                                                                    |        |                    |
|                                                                                                      | patient's were no    | t admitted due to                                         |                    |               |                                                                    |        |                    |
|                                                                                                      | 11 1                 | s or their inability to                                   |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | e and services the                                        |                    |               |                                                                    |        |                    |
|                                                                                                      | potential clients    | need.                                                     |                    |               |                                                                    |        |                    |
|                                                                                                      | 0 An undeted n       | olicy titled "Client                                      |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | ess" C- 140, indicated "                                  |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | ferred to the agency shall                                |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | a Registered Nurse to                                     |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | imediate care and                                         |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | the client; and for                                       |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | nine eligibility for home                                 |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | The initial assessment                                    |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | d within forty - eight                                    |                    |               |                                                                    |        |                    |
|                                                                                                      | •                    | erral or within forty -                                   |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | of the client's return                                    |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | receipt of a signed                                       |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | d / client requested start                                |                    |               |                                                                    |        |                    |
|                                                                                                      | of care date "       | -                                                         |                    |               |                                                                    |        |                    |
| G 0334                                                                                               | 484.55(b)(1)         |                                                           |                    |               |                                                                    |        |                    |
| - 5551                                                                                               |                      | THE COMPREHENSIVE                                         |                    |               |                                                                    |        |                    |
| Bldg. 00                                                                                             | ASSESSMENT           |                                                           |                    |               |                                                                    |        |                    |
|                                                                                                      | · ·                  | ve assessment must be<br>lely manner, consistent          |                    |               |                                                                    |        |                    |
|                                                                                                      |                      | mmediate needs, but no                                    |                    |               |                                                                    |        |                    |
|                                                                                                      | later than 5 calend  | dar days after the start of                               |                    |               |                                                                    |        |                    |
|                                                                                                      | care.                |                                                           |                    | 2.4           | Director of Nursing/designs                                        | au     | 00/05/0015         |
|                                                                                                      | Based on record      | review and interview,                                     | G 03               | 34            | Director of Nursing/designee w                                     | /111   | 08/25/2017         |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 120 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                   | (X2) MULTIPLE CONSTRUCTION   |       |          | (X3) DATE SURVEY                                                                                   |            |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|------------------------------|-------|----------|----------------------------------------------------------------------------------------------------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                     | IDENTIFICATION NUMBER:       | A. BU | ILDING   | 00                                                                                                 | COMPLETED  |
|                                                      |                                                                                                                   | 15K064                       | B. WI | NG       |                                                                                                    | 06/05/2017 |
|                                                      |                                                                                                                   |                              |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                     |            |
| NAME OF F                                            | PROVIDER OR SUPPLIEF                                                                                              | ₹                            |       |          | 82ND ST STE 216                                                                                    |            |
| AT HOMI                                              | E HEALTH SERVIC                                                                                                   | CES LLC                      |       |          | APOLIS, IN 46250                                                                                   |            |
| (X4) ID                                              |                                                                                                                   | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                                      | (X5)       |
| PREFIX                                               | · ·                                                                                                               | ICY MUST BE PRECEDED BY FULL |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) |            |
| TAG                                                  |                                                                                                                   | LSC IDENTIFYING INFORMATION) | +     | TAG      | ,                                                                                                  | DATE       |
|                                                      |                                                                                                                   | d to ensure that the         |       |          | in-service nurses on completing<br>proper assessment and                                           | ig a       |
|                                                      | Registered Nurse comprehensive                                                                                    |                              |       |          | documenting findings – this is                                                                     | to         |
|                                                      | assessment was complete and included                                                                              |                              |       |          | include assessing g-tube site i                                                                    |            |
|                                                      | skin assessments of gastric tube and                                                                              |                              |       |          | has one, clarifying patient's die                                                                  |            |
|                                                      | urostomy sites,                                                                                                   | diet clarified, and failed   |       |          | when patient has a feeding tub                                                                     |            |
|                                                      | to completely as                                                                                                  | sess a patients pain and     |       |          | and/or has a history of choking                                                                    | g, if      |
|                                                      | respiratory syste                                                                                                 | em in 2 out of 4 records     |       |          | has pain how does patient manage it, if patient has                                                |            |
|                                                      |                                                                                                                   | ents with skilled nursing    |       |          | shortness of breath how do the                                                                     | 2V         |
|                                                      | •                                                                                                                 | nple of 10. (#4 and 6)       |       |          | relieve it, if patient has any typ                                                                 | · .        |
|                                                      | Services in a sair                                                                                                | inpre of 10. (ii t and 0)    |       |          | ostomy describe skin around                                                                        |            |
|                                                      | Findings include                                                                                                  | · ·                          |       |          | area. (To be done by 8/25/17)                                                                      |            |
|                                                      | rindings include                                                                                                  | <del>.</del>                 |       |          | Director of Nursing will be                                                                        |            |
|                                                      |                                                                                                                   | 10                           |       |          | responsible to ensure orientati                                                                    |            |
|                                                      |                                                                                                                   | record for patient #4,       |       |          | of newly hired nurses includes<br>training on completing a prope                                   |            |
|                                                      | SOC (start of ca                                                                                                  | re) 4/24/17, was             |       |          | assessment and documenting                                                                         |            |
|                                                      | reviewed.                                                                                                         |                              |       |          | findings – this is to include                                                                      |            |
|                                                      |                                                                                                                   |                              |       |          | assessing g-tube site if has on                                                                    | e,         |
|                                                      | A. Review                                                                                                         | of a comprehensive           |       |          | clarifying patient's diet when                                                                     |            |
|                                                      | assessment date                                                                                                   | d 4/24/17, indicated in      |       |          | patient has a feeding tube and                                                                     |            |
|                                                      | the "Professiona                                                                                                  | l Services" narrative note   |       |          | has a history of choking, if has                                                                   |            |
|                                                      | that the patient h                                                                                                | nad an increase incidence    |       |          | pain how does patient manage<br>if patient has shortness of brea                                   |            |
|                                                      | -                                                                                                                 | a g-tube (feeding tube in    |       |          | how do they relieve it, if patien                                                                  |            |
|                                                      | _                                                                                                                 | aced last week still         |       |          | has any type of ostomy descril                                                                     |            |
|                                                      |                                                                                                                   | ds but all medication is     |       |          | skin around area. (To begin by                                                                     | /          |
|                                                      | _                                                                                                                 | ough the g-tube. With        |       |          | 8/25/17)                                                                                           |            |
|                                                      |                                                                                                                   | -                            |       |          | Director of Nursing/designee v                                                                     |            |
|                                                      |                                                                                                                   | piking, patient is being     |       |          | audit all nursing documentation weekly to monitor for complian                                     |            |
|                                                      |                                                                                                                   | so has Trilogy machine       |       |          | with completing and document                                                                       |            |
|                                                      |                                                                                                                   | ited he / she uses Trilogy   |       |          | a complete appropriate                                                                             |            |
|                                                      | when sleeping                                                                                                     | "                            |       |          | assessment until 100%                                                                              |            |
|                                                      |                                                                                                                   |                              |       |          | compliance is achieved. Once                                                                       |            |
|                                                      | 1. Review of the integumentary section and the gastrointestinal section, the admitting registered nurse failed to |                              |       |          | 100% compliance is achieved,                                                                       |            |
|                                                      |                                                                                                                   |                              |       |          | 25% of nursing documentation will be audited monthly to mon                                        |            |
|                                                      |                                                                                                                   |                              |       |          | for compliance. (To begin by                                                                       | iitOi      |
| ı                                                    |                                                                                                                   | sment of the g-tube site.    |       |          | 8/25/17)                                                                                           |            |
|                                                      |                                                                                                                   | C                            |       |          | Director of Nursing will be                                                                        |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPI<br>A. BUILDIN<br>B. WING                                                                                                                         | le construction<br>ig <u>00</u> | COMP                                                                                         | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                               | 652                             | EET ADDRESS, CITY, STATE, ZIP CODE<br>25 E 82ND ST STE 216<br>DIANAPOLIS, IN 46250           |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                             | ID<br>PREFI<br>TAG              | CROSS-REFERENCED TO THE APPRO                                                                | ON<br>DBE<br>PRIATE                   | (X5)<br>COMPLETION<br>DATE |
| TAG                                                                                                        | 2. Revistatus, the diet in HD." Due to the choking and feed admitting register clarify the patient attending physic 3. Revisassessment, the anurse failed to comby leaving patter worse / better, and or non-pharmacomeasures.  4. Revisassessment, the assessment, the assessment, the assessment, the assessment, the assessment is status of the company of | ew of the nutritional adicated a regular 2 "Kal e patient's assessment of ding tube placement, the ered nurse failed to at's diet with the                    | TAG                             | responsible for monitoring corrective actions to ensur deficiencies are corrected not recur. | е                                     | DATE                       |
|                                                                                                            | the patient uses to breath (Rescue of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | to relieve shortness of exgyen with Trilogy of machine when                                                                                                   |                                 |                                                                                              |                                       |                            |
|                                                                                                            | 2. The clinical r<br>SOC 1/30/17, w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ecord for patient #6, ras reviewed.                                                                                                                           |                                 |                                                                                              |                                       |                            |
|                                                                                                            | comprehensive a indicated in the 'narrative note th urostomy bag an around the stoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | of the start of care assessment dated 1/30/17, 'Professional Services" at the patient had a d required the wafer a site to be changed apprehensive assessment |                                 |                                                                                              |                                       |                            |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                    | A. B                                                                                                                                                                                                                                                                                                       | A. BUILDING 00  B. WING |                                                  | COMPLETED 06/05/2017                                                                                                   |    |                            |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|----|----------------------------|
| NAME OF F                                             | PROVIDER OR SUPPLIER                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                            | •                       | 1                                                | DDRESS, CITY, STATE, ZIP CODE                                                                                          | _  |                            |
| AT HOM                                                | E HEALTH SERVIC                                                                                                                                                                                                    | ES LLC                                                                                                                                                                                                                                                                                                     |                         | 6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                                        |    |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                     | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                          |                         | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|                                                       |                                                                                                                                                                                                                    | a skin assessment of the                                                                                                                                                                                                                                                                                   |                         |                                                  |                                                                                                                        |    |                            |
|                                                       | Services and Em<br>Assistant Director<br>had no further in                                                                                                                                                         | n relation to the above                                                                                                                                                                                                                                                                                    |                         |                                                  |                                                                                                                        |    |                            |
|                                                       | further informati                                                                                                                                                                                                  | the Alternate and Employee B, had no son or documentation by ace on 6/5/17 at 3:50 p.m.                                                                                                                                                                                                                    |                         |                                                  |                                                                                                                        |    |                            |
|                                                       | 145, indicated "health status / sy agency compreh with OASIS will status Formal intervention, and Integumentary status is assessment, preveffective healing status is assessed prioritized based clients will have | c Client Assessment" C In addition to general stem assessment, the ensive assessment tool include Respiratory Pain Assessment, pain I management tatus. Pressure ulcer risk rention measures and g principles Nutritional I Assessments are on client need. All the Comprehensive nt completed within five |                         |                                                  |                                                                                                                        |    |                            |
| G 0337<br>Bldg. 00                                    | 484.55(c)<br>DRUG REGIMEN<br>The comprehensiv                                                                                                                                                                      | REVIEW<br>ve assessment must                                                                                                                                                                                                                                                                               |                         |                                                  |                                                                                                                        |    |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 123 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                               | (X2) M                                              | i '                          |                        | (X3) DATE                                                            | SURVEY |            |
|------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------|------------------------|----------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                 | IDENTIFICATION NUMBER:                              | A. BUILDING <u>00</u> COMPLI |                        |                                                                      | ETED   |            |
|                                                      |                                                                               | 15K064                                              | B. W                         | NG                     |                                                                      | 06/05/ | /2017      |
|                                                      |                                                                               |                                                     |                              | STREET A               | ADDRESS, CITY, STATE, ZIP CODE                                       |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                                          | 8                                                   |                              | 6525 E                 | 82ND ST STE 216                                                      |        |            |
|                                                      | E HEALTH SERVIC                                                               | CES LLC                                             |                              | INDIANAPOLIS, IN 46250 |                                                                      |        |            |
| (X4) ID                                              |                                                                               | TATEMENT OF DEFICIENCIES                            |                              | ID                     | PROVIDER'S PLAN OF CORRECTION                                        |        | (X5)       |
| PREFIX                                               | `                                                                             | CY MUST BE PRECEDED BY FULL                         |                              | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE     | COMPLETION |
| TAG                                                  |                                                                               | LSC IDENTIFYING INFORMATION)                        |                              | TAG                    | DEFICIENCY)                                                          |        | DATE       |
|                                                      |                                                                               | of all medications the                              |                              |                        |                                                                      |        |            |
|                                                      |                                                                               | y using in order to identify                        |                              |                        |                                                                      |        |            |
|                                                      | 1 .                                                                           | erse effects and drug  ig ineffective drug therapy, |                              |                        |                                                                      |        |            |
|                                                      |                                                                               | iects, significant drug                             |                              |                        |                                                                      |        |            |
|                                                      |                                                                               | cate drug therapy, and                              |                              |                        |                                                                      |        |            |
|                                                      | noncompliance wi                                                              |                                                     |                              |                        |                                                                      |        |            |
|                                                      | Based on record                                                               | reviewed and interview,                             | G 0                          | 337                    | Director of Nursing/designee v                                       | vill   | 08/25/2017 |
|                                                      | the agency failed                                                             | d to ensure that the                                |                              |                        | in-service nurses on need to ensure medication profile is            |        |            |
|                                                      | medication profi                                                              | le was updated upon                                 |                              |                        | complete – to include name of                                        |        |            |
|                                                      | initiation of new                                                             | orders in 1 out of 8                                |                              |                        | physician and number, pharma                                         |        |            |
|                                                      | active records re                                                             | eviewed (#3) in a sample                            |                              |                        | name and number, who                                                 | ,      |            |
|                                                      | of 10 and failed to ensure the medication profile include correct start date, |                                                     |                              |                        | administers meds, start dates of meds purpose of meds, purpose       |        |            |
|                                                      |                                                                               |                                                     |                              |                        |                                                                      |        |            |
|                                                      | physician, phone                                                              | •                                                   |                              |                        | of meds, side effects of meds is updated when there is a             | and    |            |
|                                                      | 1 2 2                                                                         | narmacy, purpose of                                 |                              |                        | medication change. If nurse is                                       |        |            |
|                                                      | 1                                                                             | potential side effects in                           |                              |                        | setting up medications for pati                                      |        |            |
|                                                      |                                                                               | records reviewed in a                               |                              |                        | and there are certain meds                                           |        |            |
|                                                      |                                                                               |                                                     |                              |                        | patient handles themselves the                                       |        |            |
|                                                      | sample of 10. (#                                                              | 4, 8 and 9)                                         |                              |                        | to be documented on medicati profile and on the Plan of              | on     |            |
|                                                      | Findings include                                                              |                                                     |                              |                        | Care/verbal order. Nurses to                                         |        |            |
|                                                      |                                                                               |                                                     |                              |                        | make sure dates listed are                                           | 17)    |            |
|                                                      | 1. The clinical r                                                             | record for patient #3,                              |                              |                        | correct. (To be done by 8/25/ Director of Nursing will be            | 17)    |            |
|                                                      |                                                                               | was reviewed on 5/31/17.                            |                              |                        | responsible to ensure orientati                                      | on     |            |
|                                                      | ·                                                                             | and the medication                                  |                              |                        | of newly hired nurses includes                                       |        |            |
|                                                      | -                                                                             | the patient was taking                              |                              |                        | training on ensure medication                                        |        |            |
|                                                      |                                                                               | odium (synthroid) 25                                |                              |                        | profile is complete – to include name of physician and numbe         |        |            |
|                                                      | <u> </u>                                                                      | igrams), 1 tablet every                             |                              |                        | pharmacy name and number,                                            | ٠,     |            |
|                                                      |                                                                               | esday, and Friday.                                  |                              |                        | who administers meds, start                                          |        |            |
|                                                      | inoliday, wedne                                                               | oung, una 1 may.                                    |                              |                        | dates of meds purpose of med                                         |        |            |
|                                                      | A During a                                                                    | home visit on 6/1/17 at                             |                              |                        | purpose of meds, side effects                                        |        |            |
|                                                      | I -                                                                           | ece of paper was observed                           |                              |                        | meds and is updated when the is a medication change. If nurs         |        |            |
|                                                      |                                                                               | • •                                                 |                              |                        | is setting up medications for                                        |        |            |
|                                                      | on the patient's t                                                            |                                                     |                              |                        | patient and there are certain                                        |        |            |
|                                                      |                                                                               | es were located. The                                |                              |                        | meds patient handles themsel                                         | ves    |            |
|                                                      | piece of paper in                                                             | ndicated between 5/22/17                            |                              |                        | this is to be documented on                                          |        |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 124 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. BUI                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                              |                                                  | 6525 E              | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                    |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                            | I                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                 | ΓE                                    | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            | mcg daily. Durinurse and the paramanges the synand that the skill medication in the request. The parameters of synthemedication profit with the accurate 2. The clinical responsible indicated medications star medication faile year the patient's 3. The clinical responsible indicated medication faile year the patient's 3. The clinical responsible information such physician, phonorand pharmacy, demedication was semedications and 4. The clinical responsible information such medication physician, phonorand pharmacy, demedication and 4. The clinical responsible information such physician, phonorand pharmacy, demedication and 4. The clinical responsible information such physician phonorand pharmacy, demedication and 4. The clinical responsible information such physician phonorand pharmacy, demedication and 4. The clinical responsible information such physician phonorand pharmacy, demedication and 4. The clinical responsible information such physician phonorand pharmacy, demedication physician phonorand pharmacy physician | n as the name of e number of the physician lates of when the tarted, purpose of potential side effects. lecord for patient #9, s reviewed. Review of profile, the Registered include patient |                                                  |                     | medication profile and on the Plan of Care/verbal order. Nur to make sure dates are correct (To begin by 8/25/17)  Director of Nursing/designee valudit all medication profiles on new admissions, re-certification resumptions to monitor for compliance with the above. Or 100% compliance is achieved 25% of medication profiles for admissions, re-certs, resumpti will be audited monthly to monocompliance. (To begin by 8/25/17) | t.<br>vill<br>ns,<br>nce<br>ons       |                            |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | r í                                                                                                                                                                         | UILDING | 00                  | COMPLETED 06/05/2017                                                                                                  |     |                            |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------|-----------------------------------------------------------------------------------------------------------------------|-----|----------------------------|
| NAME OF I                                             | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                             |         |                     | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                      |     |                            |
| AT HOM                                                | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ES LLC                                                                                                                                                                      |         |                     | APOLIS, IN 46250                                                                                                      |     |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                           |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE | (X5)<br>COMPLETION<br>DATE |
| G 0339                                                | administered by, medicaton was s medications and  5. Employee B, Services and Em Assistant Director had no further in documentation in findings on 6/2/1  6. Employee A, Administrator ar further information the exit conference of | the Alternate and Employee B, had no on or documentation by the on 6/5/17 at 3:50 p.m. olicy titled "Medication indicated" The ile shall document ordered or care initiated |         |                     |                                                                                                                       |     |                            |
| Bldg. 00                                              | UPDATE OF THE<br>ASSESSMENT<br>The comprehensiv<br>updated and revis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | COMPREHENSIVE  /e assessment must be ed (including the he OASIS) the last 5 days                                                                                            |         |                     |                                                                                                                       |     |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet

Page 126 of 247

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED 15K064 B. WING 06/05/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6525 E 82ND ST STE 216 AT HOME HEALTH SERVICES LLC INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. G 0339 Director of Nursing/designee will 08/25/2017 Based on record review and interview. in-service nurses on conducting a the agency failed to ensure that the complete assessment at start of Registered Nurse conducted a complete care, recertification - this is to skin assessment in 2 of 2 active records include a complete skin assessment. If patient has skin reviewed of a patient receiving wound impairments, including wounds, treatments with a Medicare agency in a nurse will assess those areas and sample of 10. (#7 and 8) document findings. If it is documented patient has a wound then all documentation for that Findings include: patient for that time needs to reflect the same thing. (To be 1. The clinical record for patient #7, done by 8/25/17) SOC 12/31/16, included a plan of care for Director of Nursing will be responsible to ensure orientation the certification period of 4/9/17 to of newly hired nurses includes 6/7/17, with orders for home health aide training on conducting a complete services up to 6 hours per day, 7 days a assessment at start of care. week. recertification - this is to include a complete skin assessment. If patient has skin impairments. A. Review of a recertification including wounds, nurse will comprehensive assessment dated 4/7/17. assess those areas and the "Professional Services" narrative document findings. If it is section indicated the patient was documented patient has a wound then all documentation for that receiving home health services with a patient for that time needs to Medicare agency for wound treatments. reflect the same thing. (To begin The comprehensive assessment failed to by 8/25/17) Director of Nursing/designee will evidence an complete skin assessment, audit 100% of admission and including visual site, of the patient's re-certifications to monitor for wounds. The clinical record failed to compliance with documenting a evidence the attempted coordination with complete assessment, to include skin. Once 100% compliance is the Medicare agency.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11

Facility ID: 012383

If continuation sheet

Page 127 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION   |          |          | (X3) DATE SURVEY                                                        |            |  |
|------------------------------------------------------|----------------------|------------------------------|----------|----------|-------------------------------------------------------------------------|------------|--|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BU    | JILDING  | 00                                                                      | COMPLETED  |  |
|                                                      |                      | 15K064                       | B. W     | ING      |                                                                         | 06/05/2017 |  |
|                                                      |                      |                              | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                          |            |  |
| NAME OF F                                            | PROVIDER OR SUPPLIER |                              |          |          | 82ND ST STE 216                                                         |            |  |
| AT HOM                                               | E HEALTH SERVIC      | ES LLC                       |          |          | APOLIS, IN 46250                                                        |            |  |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES     |          | ID       | PROVIDER'S PLAN OF CORRECTION                                           | (X5)       |  |
| PREFIX                                               | (EACH DEFICIEN       | CY MUST BE PRECEDED BY FULL  |          | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | COMPLETION |  |
| TAG                                                  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) |          | TAG      | DEFICIENCY)                                                             | DATE       |  |
|                                                      |                      |                              |          |          | achieved 25% of admissions,                                             |            |  |
|                                                      | B. A comm            | unication log dated          |          |          | re-certifications will be audited                                       |            |  |
|                                                      | 5/2/17, indicated    | that the patient was         |          |          | monthly to monitor for                                                  |            |  |
|                                                      |                      | nealth services with a       |          |          | compliance. (To begin by 8/25/17)                                       |            |  |
|                                                      |                      | re agency for the            |          |          | Director of Nursing will in-servi                                       | ce         |  |
|                                                      | treatment of wou     | • •                          |          |          | nurses on coordinating care wi                                          |            |  |
|                                                      | l cament of wor      | mas.                         |          |          | all medical agencies involved v                                         | vith       |  |
|                                                      |                      | i. id d. Di e c              |          |          | patient. Training will include                                          |            |  |
|                                                      |                      | view with the Director of    |          |          | documenting name of agency,                                             |            |  |
|                                                      |                      | s on 5/31/17 at 11:00        |          |          | name/title of person spoke with<br>payer, discipline(s), frequency,     | *          |  |
|                                                      |                      | r of Clinical Services       |          |          | duration and tasks to be provide                                        |            |  |
|                                                      | indicated that she   | e was not able to set up a   |          |          | (To be done by 8/25/17)                                                 |            |  |
|                                                      | joint visit with th  | ne Medicare agency, but      |          |          | Director of Nursing will be                                             |            |  |
|                                                      | did not indicate     | which agency the patient     |          |          | responsible to ensure orientati                                         |            |  |
|                                                      | was with. The D      | Director of Clinical         |          |          | of newly hired nurses includes                                          |            |  |
|                                                      | Services indicate    | ed she did not want to       |          |          | training on coordinating care w                                         |            |  |
|                                                      | disrupt the patien   | nt's dressing to assess the  |          |          | all medical agencies involved versitient. Training will include         | WILLI      |  |
|                                                      | patient's skin.      | 8                            |          |          | documenting name of agency,                                             |            |  |
|                                                      | <b>F</b>             |                              |          |          | name/title of person spoke with                                         |            |  |
|                                                      |                      |                              |          |          | payer, discipline(s), frequency,                                        |            |  |
|                                                      | 2. The clinical re   | ecord for patient #8,        |          |          | duration and tasks to be                                                | 7)         |  |
|                                                      |                      | luded a plan of care for     |          |          | provided. (To begin by 8/25/1                                           | ' I        |  |
|                                                      |                      | period of 3/31/17 to         |          |          | Director of Nursing/designee will                                       |            |  |
|                                                      |                      | an of care indicated the     |          |          | audit 100% of admissions,                                               |            |  |
|                                                      | _                    | ving skilled nursing and     |          |          | resumptions and re-certifications                                       | ·          |  |
|                                                      | home health aide     | -                            |          |          | to monitor for compliance of                                            |            |  |
|                                                      |                      |                              |          |          | coordinating care with other                                            |            |  |
|                                                      | Medicare agency      | <i>'</i> -                   |          |          | medical agencies, if there are                                          |            |  |
|                                                      |                      |                              |          |          | any. (To begin by 8/25/17)                                              |            |  |
|                                                      |                      | of the OASIS start of care   |          |          |                                                                         |            |  |
|                                                      | _                    | ssessment dated 8/3/16,      |          |          |                                                                         |            |  |
|                                                      |                      | I Services" narrative        |          |          |                                                                         |            |  |
|                                                      | _                    | ient was receiving home      |          |          |                                                                         |            |  |
|                                                      | health services 3    | times a week through a       |          |          |                                                                         |            |  |
|                                                      | Medicare agency      | for management of            |          |          |                                                                         |            |  |
|                                                      | pressure wounds      | to the patient's right arm   |          |          |                                                                         |            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                           | (X2) MULTIPLE CONSTRUCTION (X3) DA                       |       |               | (X3) DATE S                                                        | SURVEY |                    |
|------------------------------------------------------|-------------------------------------------|----------------------------------------------------------|-------|---------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN                                             | OF CORRECTION                             | IDENTIFICATION NUMBER:                                   | A. BU | JILDING       | 00                                                                 | COMPL  | ETED               |
|                                                      |                                           | 15K064                                                   | B. W  | ING           |                                                                    | 06/05/ | 2017               |
|                                                      |                                           |                                                          |       | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
| NAME OF F                                            | PROVIDER OR SUPPLIER                      | t                                                        |       |               | 82ND ST STE 216                                                    |        |                    |
| AT HOM                                               | E HEALTH SERVIC                           | CESTIC                                                   |       |               | APOLIS, IN 46250                                                   |        |                    |
|                                                      |                                           |                                                          | _     |               | 74 0210, 114 10200                                                 |        |                    |
| (X4) ID                                              |                                           | TATEMENT OF DEFICIENCIES                                 |       | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| PREFIX<br>TAG                                        | ì ·                                       | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |       | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)                     | TE     | COMPLETION<br>DATE |
| TAG                                                  |                                           | LISC IDENTIFTING INFORMATION)                            | +     | TAG           |                                                                    |        | DATE               |
|                                                      | and buttocks.                             |                                                          |       |               |                                                                    |        |                    |
|                                                      |                                           | 0.1 0.1 0.2                                              |       |               |                                                                    |        |                    |
|                                                      |                                           | of the OASIS                                             |       |               |                                                                    |        |                    |
|                                                      | comprehensive recertification assessment  |                                                          |       |               |                                                                    |        |                    |
|                                                      | dated 1/25 and 3                          | /30/17, the "Professional                                |       |               |                                                                    |        |                    |
|                                                      |                                           | ve indicated the patient                                 |       |               |                                                                    |        |                    |
|                                                      |                                           | filled nursing and home                                  |       |               |                                                                    |        |                    |
|                                                      | health aide servi                         | ces through a Medicare                                   |       |               |                                                                    |        |                    |
|                                                      | agency. The ski                           | n assessments indicated                                  |       |               |                                                                    |        |                    |
|                                                      | the patient did no                        | ot have a wound.                                         |       |               |                                                                    |        |                    |
|                                                      |                                           |                                                          |       |               |                                                                    |        |                    |
|                                                      | C. The hom                                | e health aide written                                    |       |               |                                                                    |        |                    |
|                                                      | patient instruction                       | ons dated 3/30/17,                                       |       |               |                                                                    |        |                    |
|                                                      |                                           | home health aide to                                      |       |               |                                                                    |        |                    |
|                                                      | inspect the patie                         |                                                          |       |               |                                                                    |        |                    |
|                                                      | mspeet the patie.                         | int's diessing.                                          |       |               |                                                                    |        |                    |
|                                                      | The clinical reco                         | ord failed to be consistent                              |       |               |                                                                    |        |                    |
|                                                      |                                           | patient's wound status,                                  |       |               |                                                                    |        |                    |
|                                                      |                                           | ee an assessment of the                                  |       |               |                                                                    |        |                    |
|                                                      |                                           |                                                          |       |               |                                                                    |        |                    |
|                                                      | wound, and faile                          |                                                          |       |               |                                                                    |        |                    |
|                                                      |                                           | / narrative notes related                                |       |               |                                                                    |        |                    |
|                                                      | to the error.                             |                                                          |       |               |                                                                    |        |                    |
|                                                      | 2 F 1 F                                   | d Di e coli i l                                          |       |               |                                                                    |        |                    |
|                                                      | 1 2 /                                     | the Director of Clinical                                 |       |               |                                                                    |        |                    |
|                                                      |                                           | ed on 6/2/17 at 4:15 p.m.,                               |       |               |                                                                    |        |                    |
|                                                      |                                           | was having issues with                                   |       |               |                                                                    |        |                    |
|                                                      |                                           | rogram and she had                                       |       |               |                                                                    |        |                    |
|                                                      | notified the com                          | pany on the problem.                                     |       |               |                                                                    |        |                    |
|                                                      | Employee B ind                            | icated in the meantime,                                  |       |               |                                                                    |        |                    |
|                                                      | the nursing staff                         | was to write a                                           |       |               |                                                                    |        |                    |
|                                                      | communication                             | note / narrative indicating                              |       |               |                                                                    |        |                    |
|                                                      | the problem and correctly identifying the |                                                          |       |               |                                                                    |        |                    |
|                                                      | -                                         | ne correct answers.                                      |       |               |                                                                    |        |                    |
|                                                      | -                                         | s not able to provide                                    |       |               |                                                                    |        |                    |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NZKC11 Facility ID: 012383

If continuation sheet Page 129 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                               | (X2) MI                                                                                                  | X2) MULTIPLE CONSTRUCTION (X3) |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (3) DATE SURVEY |            |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                                                                                                 | IDENTIFICATION NUMBER:                                                                                   | A. BU                          | ILDING   | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | COMPL           | ETED       |
|                                                      |                                                                                                                                                                                                                                                                                                                               | 15K064                                                                                                   | B. WI                          | NG       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 06/05/          | 2017       |
|                                                      |                                                                                                                                                                                                                                                                                                                               | <u> </u>                                                                                                 | <u> </u>                       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <u> </u>        |            |
| NAME OF F                                            | PROVIDER OR SUPPLIE                                                                                                                                                                                                                                                                                                           | R                                                                                                        |                                | 1        | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |            |
| AT HOMI                                              | E HEALTH SERVIO                                                                                                                                                                                                                                                                                                               | CES LLC                                                                                                  | INDIANAPOLIS                   |          | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                 |            |
| (X4) ID                                              | SUMMARY S                                                                                                                                                                                                                                                                                                                     | STATEMENT OF DEFICIENCIES                                                                                |                                | ID       | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                 | (X5)       |
| PREFIX                                               |                                                                                                                                                                                                                                                                                                                               | NCY MUST BE PRECEDED BY FULL                                                                             |                                | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TE              | COMPLETION |
| TAG                                                  |                                                                                                                                                                                                                                                                                                                               | R LSC IDENTIFYING INFORMATION)                                                                           |                                | TAG      | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                 | DATE       |
|                                                      |                                                                                                                                                                                                                                                                                                                               | communication with the                                                                                   |                                |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |            |
|                                                      | computer softwa                                                                                                                                                                                                                                                                                                               | are company.                                                                                             |                                |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |            |
| G 0341                                               |                                                                                                                                                                                                                                                                                                                               | E COMPREHENSIVE                                                                                          |                                |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |            |
| Bldg. 00                                             | updated and revis                                                                                                                                                                                                                                                                                                             | ive assessment must be<br>sed (including the<br>the OASIS) at discharge.                                 |                                |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |            |
|                                                      | Based on record                                                                                                                                                                                                                                                                                                               | I review and interview,                                                                                  | G 0.                           | 341      | Director of Nursing/designee v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 | 08/25/2017 |
|                                                      | the agency faile                                                                                                                                                                                                                                                                                                              | d to ensure the Registered                                                                               |                                |          | in-service nurses on needing t                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                 |            |
|                                                      |                                                                                                                                                                                                                                                                                                                               | d a discharge assessment                                                                                 |                                |          | make a discharge visit. If patie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                 |            |
|                                                      | •                                                                                                                                                                                                                                                                                                                             | illed nursing visit in 1 of                                                                              |                                |          | refuses a visit or is hospitalize discharge, the discharge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ed at           |            |
|                                                      |                                                                                                                                                                                                                                                                                                                               | cords reviewed in a                                                                                      |                                |          | assessment is based on the la                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ast             |            |
|                                                      | _                                                                                                                                                                                                                                                                                                                             |                                                                                                          |                                |          | assessment. Nurse must indic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                 |            |
|                                                      | sample of 10. (                                                                                                                                                                                                                                                                                                               | #10)                                                                                                     |                                |          | on the discharge when a visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | not             |            |
|                                                      | Findings include                                                                                                                                                                                                                                                                                                              | e:                                                                                                       |                                |          | made what assessment date documentation is being used t complete the discharge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | to              |            |
|                                                      | 1. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activies of daily living, meal prep, medication |                                                                                                          |                                |          | assessment. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientat of newly hired nurses includes training on needing to make a discharge visit. If patient refus a visit or is hospitalized at discharge, the discharge assessment is based on the later than the second se | es<br>est       |            |
|                                                      | reminders and li<br>care plan.                                                                                                                                                                                                                                                                                                | ight housekeeping per                                                                                    |                                |          | assessment. Nurse must indic<br>on the discharge when a visit<br>made what assessment date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                 |            |
|                                                      | discharge OASI<br>dated 4/2/17. T                                                                                                                                                                                                                                                                                             | ical record evidenced a S discharge assessment he discharge assessment Employee C, Interimical Services. |                                |          | documentation is being used to complete the discharge assessment. (To begin by 8/25/17)  Director of Nursing/designee wandit all discharges to monitor compliance with making a discharge visit and if one isn't made, the purse has documentation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | will<br>for     |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                        | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                                 |                      |
|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                              | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>NAPOLIS, IN 46250                                                                                                                |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                     | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                         | (X5) COMPLETION DATE |
|                                                                                                              | B. The 1/3/17 and the 3/2/17 skilled nursing recertification assessments was conducted by a former employee.  2. An interview with the Employee C, on 5/31/17 at 2:30 p.m., indicated a discharge visit was not conducted. The employee indicated the assessment was based off her own assessment but could not indicate when the last time she had assessed the patient. Employee C indicated the former Director of Clinical Services took over as the patient's case manager last year and provided the last skilled nursing assessment. |                                                                                   |                     | what assessment date paperwis being used to complete the discharge. Once 100% compliance is achieved 25% of discharges will audited monthl monitor for compliance. (To be by 8/25/17) | of<br>y to           |
| N 0000                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   |                     |                                                                                                                                                                                       |                      |
| Bldg. 00                                                                                                     | with complaint s  Survey Dates: M 5, 2017  Complaint numb Substantiated; Fedeficiencies were                                                                                                                                                                                                                                                                                                                                                                                                                                                | May 30, 31, June 1, 2, and er: IN00178995 ederal and State e cited                | N 0000              |                                                                                                                                                                                       |                      |
|                                                                                                              | Facility Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | : 012383                                                                          |                     |                                                                                                                                                                                       |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 131 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                         | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 00 COMPLET |      |                        |                                                                                                    |        |            |
|----------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------|------|------------------------|----------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                                                                           | OF CORRECTION                           | IDENTIFICATION NUMBER: 15K064                                   | B. W |                        | 00                                                                                                 | 06/05/ |            |
|                                                                                                    |                                         | 131004                                                          |      |                        | A DDDDGG CUTY CTATE TID CODE                                                                       | 00/03/ | 2017       |
| NAME OF P                                                                                          | ROVIDER OR SUPPLIER                     |                                                                 |      |                        | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                  |        |            |
| AT HOME                                                                                            | E HEALTH SERVIC                         | ES LLC                                                          |      | INDIANAPOLIS, IN 46250 |                                                                                                    |        |            |
| (X4) ID                                                                                            |                                         | TATEMENT OF DEFICIENCIES                                        |      | ID                     | PROVIDER'S PLAN OF CORRECTION                                                                      |        | (X5)       |
| PREFIX                                                                                             |                                         | CY MUST BE PRECEDED BY FULL                                     |      | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | íΕ     | COMPLETION |
| TAG                                                                                                | REGULATORY OR                           | LSC IDENTIFYING INFORMATION)                                    |      | TAG                    | DEFICIENC!)                                                                                        |        | DATE       |
|                                                                                                    | Medicaid Number                         | er: 201005950A                                                  |      |                        |                                                                                                    |        |            |
|                                                                                                    | Census: 71                              |                                                                 |      |                        |                                                                                                    |        |            |
|                                                                                                    | Sample: 10                              |                                                                 |      |                        |                                                                                                    |        |            |
| N 0458                                                                                             | 410 IAC 17-12-1(f                       | ,                                                               |      |                        |                                                                                                    |        | '          |
| DI4= 00                                                                                            | Home health ager administration/mar     |                                                                 |      |                        |                                                                                                    |        |            |
| Bldg. 00                                                                                           |                                         | Personnel practices for                                         |      |                        |                                                                                                    |        |            |
|                                                                                                    | • • • • • • • • • • • • • • • • • • • • | e supported by written                                          |      |                        |                                                                                                    |        |            |
|                                                                                                    |                                         | byees caring for patients in                                    |      |                        |                                                                                                    |        |            |
|                                                                                                    |                                         | ubject to Indiana licensure,<br>gistration required to          |      |                        |                                                                                                    |        |            |
|                                                                                                    |                                         | ctive service. Personnel                                        |      |                        |                                                                                                    |        |            |
|                                                                                                    | records of employ                       | ees who deliver home                                            |      |                        |                                                                                                    |        |            |
|                                                                                                    |                                         | all be kept current and                                         |      |                        |                                                                                                    |        |            |
|                                                                                                    | the job, including t                    | mentation of orientation to                                     |      |                        |                                                                                                    |        |            |
|                                                                                                    | (1) Receipt of job                      |                                                                 |      |                        |                                                                                                    |        |            |
|                                                                                                    | (2) Qualifications                      |                                                                 |      |                        |                                                                                                    |        |            |
|                                                                                                    | · · · · · · ·                           | ted criminal history                                            |      |                        |                                                                                                    |        |            |
|                                                                                                    | pursuant to IC 16-                      | 27-2.<br>rent license, certification,                           |      |                        |                                                                                                    |        |            |
|                                                                                                    | or registration.                        | ioni noonoo, oorunoation,                                       |      |                        |                                                                                                    |        |            |
|                                                                                                    | (5) Annual perform                      | mance evaluations.                                              |      |                        |                                                                                                    |        |            |
|                                                                                                    | Based on record                         | review and interview,                                           | N 0  | 458                    | Human Resources/designee w                                                                         |        | 08/25/2017 |
|                                                                                                    | the Administrato                        | or failed to ensure that                                        |      |                        | utilize a tracking system to ensemployee evaluations are                                           | ure    |            |
|                                                                                                    | clinical staff ann                      | -                                                               |      |                        | completed every 9 to 15 month                                                                      | าร     |            |
|                                                                                                    | evaluations were                        | e completed every 9 to 15                                       |      |                        | as required by regulation. (To                                                                     | be     |            |
|                                                                                                    |                                         | of 7 employee records                                           |      |                        | completed by 8/25/17)                                                                              |        |            |
|                                                                                                    | reviewed. (Emp                          | loyee G and H).                                                 |      |                        | Human Resources will be responsible to audit all current                                           |        |            |
|                                                                                                    |                                         |                                                                 |      |                        | employee files. Any employee                                                                       |        |            |
|                                                                                                    | Findings include                        | :                                                               |      |                        | who has an evaluation that is p                                                                    | oast   |            |
|                                                                                                    |                                         |                                                                 |      |                        | due will have an evaluation                                                                        |        |            |
|                                                                                                    | 1. The personne                         | l record for Employee G,                                        |      |                        | completed by their respective supervisor. (To be completed I                                       | ov.    |            |
|                                                                                                    | a home health ai                        | de, start date 3/21/11,                                         |      |                        | Supervisor: (10 de completed  <br>  8/25/17)                                                       | Jy     |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 132 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ONSTRUCTION  00     | (X3) DATE S<br>COMPLI<br>06/05/2                                                                                                                                                                                                                                                                                                                                                                                                                            | ETED                           |                            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
| NAME OF P                                                                                                  | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                           |                                |                            |
| AT HOME                                                                                                    | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | IAPOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                                                                                                                                                                                                                                                                                                                                              | TE                             | (X5)<br>COMPLETION<br>DATE |
| N 0472<br>Bldg. 00                                                                                         | evaluation.  2. The personne a home health aid failed to evidence evaluation.  3. Employee A, Administrator, in 12:00 p.m., that I performance was Administrator but from her comput vacation. Employee H's evaluation w  410 IAC 17-12-2(a Q A and performa Rule 12 Sec. 2(a) must develop, impevaluate a quality performance improprogram must reflehome health orgar (including those secunder arrangement agency must take improvements in the performance across The home health assessment and performance | Employee G's annual accompleted by the at was not printed out er prior to her going on eyee A indicated she did to the Administrators A indicated Employee as not completed.  A) Indicated She did | N 0472              | Human Resources will be responsible to track outstanding evaluations to ensure they are completed by 8/25/17. Human Resources will notify supervisors monthly of employ evaluations due during that me and will monitor for compliance ensure evaluations are completimely. (To begin immediately) Administrator/Human Resource will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | vee onth e to eted es ing sure | 08/25/2017                 |
|                                                                                                            | the agency failed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1101/2              | Nursing/designee will be responsible to ensure quarterly                                                                                                                                                                                                                                                                                                                                                                                                    | y                              | 00/23/2017                 |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 133 of 247

| STATEMEN  | T OF DEFICIENCIES     | X1) PROVIDER/SUPPLIER/CLIA                          |          |          | ONSTRUCTION                                                                                                                              | (X3) DATE |            |
|-----------|-----------------------|-----------------------------------------------------|----------|----------|------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------|
| AND PLAN  | OF CORRECTION         | IDENTIFICATION NUMBER:                              | A. BU    | JILDING  | 00                                                                                                                                       | COMPL     | ETED       |
|           |                       | 15K064                                              | B. WI    | ING      |                                                                                                                                          | 06/05/    | 2017       |
|           |                       |                                                     | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                                                           |           |            |
| NAME OF P | PROVIDER OR SUPPLIER  |                                                     |          |          | 82ND ST STE 216                                                                                                                          |           |            |
|           | E HEALTH SERVIC       | ES LLC                                              |          |          | APOLIS, IN 46250                                                                                                                         |           | <u> </u>   |
| (X4) ID   |                       | TATEMENT OF DEFICIENCIES                            |          | ID       | PROVIDER'S PLAN OF CORRECTION                                                                                                            | (X5)      |            |
| PREFIX    | ``                    | CY MUST BE PRECEDED BY FULL                         |          | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                   | TE        | COMPLETION |
| TAG       |                       | LSC IDENTIFYING INFORMATION)                        |          | TAG      |                                                                                                                                          |           | DATE       |
|           |                       | g was conducted to                                  |          |          | QAPI is done. Director of Nurs will be responsible to obtain                                                                             | sing      |            |
|           | •                     | of the agency's program,                            |          |          | information required for QAPI                                                                                                            | and       |            |
|           | reviewed a samp       | le of both active and                               |          |          | write the report. Director of                                                                                                            |           |            |
|           | closed records to     | determine whether                                   |          |          | Nursing will be responsible to                                                                                                           |           |            |
|           | established polic     | ies were being followed                             |          |          | notify those needing to attend                                                                                                           |           |            |
|           | in furnishing ser     | vices.                                              |          |          | the meeting date and time, ha                                                                                                            |           |            |
|           | Findings include      |                                                     |          |          | materials avail for review during<br>meeting, having sign in sheet,<br>keeping meeting minutes, whin<br>will include: what was discussed | ch        |            |
|           | 1. On 6/5/17 at 2     | 2:00 p.m., the QAPI                                 |          |          | what is the plan to address                                                                                                              |           |            |
|           | (Quality Assuran      | -                                                   |          |          | issues, who will monitor and w                                                                                                           |           |            |
|           |                       | ogram was asked to be                               |          |          | the goals are for each issue. (*begin by 8/25/17)                                                                                        | 10        |            |
|           |                       | g this time, Employee A,                            |          |          | Administrator and Director of                                                                                                            |           |            |
|           |                       |                                                     |          |          | Nursing will be responsible to                                                                                                           |           |            |
|           |                       | ministrator, indicated                              |          |          | ensure any reports, reviews,                                                                                                             |           |            |
|           |                       | ot a 2017 QAPI to review                            |          |          | audits, etc. that are done by a                                                                                                          |           |            |
|           | •                     | sultant notes of their                              |          |          | outside entity that are pertiner                                                                                                         | it to     |            |
|           | _                     | ency. Employee A                                    |          |          | the QAPI requirements are                                                                                                                |           |            |
|           | indicated they di     |                                                     |          |          | included in the quarterly repor<br>The material to presented will                                                                        |           |            |
|           | information from      | n the consultant and                                |          |          | reviewed prior to meeting to                                                                                                             | DC        |            |
|           | implemented tha       | t into their QAPI                                   |          |          | ensure they contain all require                                                                                                          | d         |            |
|           | program. Emplo        | yee A indicated the                                 |          |          | information. (To begin by 8/25                                                                                                           | /17)      |            |
|           | consultant wante      | ed to wait until the end of                         |          |          |                                                                                                                                          |           |            |
|           | June - beginning      | July before coming to                               |          |          |                                                                                                                                          |           |            |
|           | the agency to ass     | ,                                                   |          |          |                                                                                                                                          |           |            |
|           |                       |                                                     |          |          |                                                                                                                                          |           |            |
|           |                       |                                                     |          |          |                                                                                                                                          |           |            |
| N 0476    | 410 IAC 17-12-2(c     |                                                     |          |          |                                                                                                                                          |           |            |
|           | Q A and performa      |                                                     |          |          |                                                                                                                                          |           |            |
| Bldg. 00  |                       | In all cases involving the health aide services the |          |          |                                                                                                                                          |           |            |
|           | •                     | cy shall provide case                               |          |          |                                                                                                                                          |           |            |
|           |                       | health care professional                            |          |          |                                                                                                                                          |           |            |
|           |                       | cope of his or her practice.                        |          |          |                                                                                                                                          |           |            |
|           | Such case manag       | ement shall include an                              |          |          |                                                                                                                                          |           |            |
|           | initial home visit fo |                                                     |          |          |                                                                                                                                          |           |            |
|           | patient's needs to    | determine the type,                                 |          |          |                                                                                                                                          |           |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 134 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY         |       |                                  |                                                                     | SURVEY |            |
|------------------------------------------------------|----------------------|-----------------------------------------------------|-------|----------------------------------|---------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:                              |       | JILDING                          | 00                                                                  | COMPL  |            |
|                                                      |                      | 15K064                                              | B. Wl | ING                              |                                                                     | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIER |                                                     | •     | STREET .                         | ADDRESS, CITY, STATE, ZIP CODE                                      |        |            |
|                                                      |                      |                                                     |       |                                  | 82ND ST STE 216                                                     |        |            |
| AT HOM                                               | E HEALTH SERVIC      | CES LLC                                             |       | INDIAN                           | IAPOLIS, IN 46250                                                   |        |            |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES                            |       | ID PROVIDER'S PLAN OF CORRECTION |                                                                     |        | (X5)       |
| PREFIX                                               | `                    | CY MUST BE PRECEDED BY FULL                         |       | PREFIX                           | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE     | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION)                        |       | TAG                              | DEFICIENCY)                                                         |        | DATE       |
|                                                      |                      | and adequacy of requested evelopment of the patient |       |                                  |                                                                     |        |            |
|                                                      | care plan.           | orenopment or the patient                           |       |                                  |                                                                     |        |            |
|                                                      | Based on record      | review and interview,                               | N 0   | 476                              | Director of Nursing/designee v                                      |        | 08/25/2017 |
|                                                      | the agency failed    | d to ensure that a                                  |       |                                  | in-service staff on requirement                                     |        |            |
|                                                      | Registered Nurs      | e conducted an initial                              |       |                                  | make initial assessment of pat within forty-eight (48) hours of     |        |            |
|                                                      | assessment visit     | in order to determine the                           |       |                                  | receiving referral. If initial                                      |        |            |
|                                                      | immediate needs      | s of patients in 7 of 8                             |       |                                  | evaluation visit cannot be mad                                      | е      |            |
|                                                      | records reviewed     | d of patients admitted                              |       |                                  | within forty-eight hours, there                                     |        |            |
|                                                      | since 2015 in a s    | sample of 10. (# 1, 3, 4,                           |       |                                  | must be documentation to support why not made (needs                | to     |            |
|                                                      | 5, 6, 8, 9)          |                                                     |       |                                  | be patient's choice) and must                                       |        |            |
|                                                      |                      |                                                     |       |                                  | made as soon as possible.                                           |        |            |
|                                                      | Findings include:    |                                                     |       |                                  | Director of Nursing will implem                                     |        |            |
|                                                      |                      |                                                     |       |                                  | a process ensuring nurses are notified of referral immediately      |        |            |
|                                                      | 1. The clinical r    | record for patient #1,                              |       |                                  | an order can be obtained to m                                       |        |            |
|                                                      |                      | OC) 03/10/15, was                                   |       |                                  | evaluation visit to assess patie                                    |        |            |
|                                                      | `                    | iled to evidence an initial                         |       |                                  | for appropriateness of home                                         |        |            |
|                                                      | assessment visit     | note.                                               |       |                                  | health care needs and eligibilit                                    | y. If  |            |
|                                                      |                      |                                                     |       |                                  | it is determined patient is not appropriate for home health ca      | are    |            |
|                                                      | 2. The clinical r    | record for patient #3,                              |       |                                  | or they refuse services, nurse                                      |        |            |
|                                                      |                      | was reviewed. The                                   |       |                                  | must notify MD of this and                                          |        |            |
|                                                      | · ·                  | ncluded a referral form                             |       |                                  | document on paperwork. (To b                                        | e      |            |
|                                                      |                      | The clinical record failed                          |       |                                  | done by 8/25/17) Director of Nursing will be                        |        |            |
|                                                      |                      | nitial assessment visit                             |       |                                  | responsible to ensure orientati                                     | on     |            |
|                                                      |                      | ours of the referral.                               |       |                                  | of newly hired nurses includes                                      |        |            |
|                                                      |                      |                                                     |       |                                  | training on requirement to make                                     | е      |            |
|                                                      | 3 The clinical r     | record for patient #4,                              |       |                                  | initial assessment of patient within forty-eight (48) hours of      |        |            |
|                                                      |                      | as reviewed. The clinical                           |       |                                  | receiving referral. If initial                                      |        |            |
|                                                      | · ·                  | a referral form dated                               |       |                                  | evaluation visit cannot be mad                                      | е      |            |
|                                                      |                      | nical record failed to                              |       |                                  | within forty-eight hours, there                                     |        |            |
|                                                      |                      | al assessment visit note                            |       |                                  | must be documentation to                                            | to     |            |
|                                                      | within 48 hours      |                                                     |       |                                  | support why not made (needs be patient's choice) and must           |        |            |
|                                                      | , idilii to nodis    | VI 1110 101011W1.                                   |       |                                  | made as soon as possible.                                           | ~~     |            |
|                                                      | 4 The clinical r     | record for patient #5,                              |       |                                  | Director of Nursing will implem                                     |        |            |
|                                                      | i. The chinear i     | ocord for putient #3,                               |       |                                  | a process ensuring nurses are                                       | !      |            |

| STATEMEN  | T OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |          | ONSTRUCTION                                                      | (X3) DATE SURVEY |            |
|-----------|----------------------|------------------------------|----------------------------|----------|------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BU                      | JILDING  | 00                                                               | COMPL            | ETED       |
|           |                      | 15K064                       | B. W                       | ING      |                                                                  | 06/05/           | 2017       |
|           |                      |                              |                            | CTDEET / | ADDRESS, CITY, STATE, ZIP CODE                                   |                  |            |
| NAME OF I | PROVIDER OR SUPPLIER | ₹                            |                            |          |                                                                  |                  |            |
| AT 110N4  |                      | 256116                       |                            |          | 82ND ST STE 216                                                  |                  |            |
| AT HOM    | E HEALTH SERVIC      | ES LLC                       |                            | INDIAN   | APOLIS, IN 46250                                                 |                  |            |
| (X4) ID   | SUMMARY S            | TATEMENT OF DEFICIENCIES     |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                    |                  | (X5)       |
| PREFIX    | (EACH DEFICIEN       | ICY MUST BE PRECEDED BY FULL |                            | PREFIX   | CROSS-REFERENCED TO THE APPROPRIATE                              |                  | COMPLETION |
| TAG       | REGULATORY OR        | LSC IDENTIFYING INFORMATION) |                            | TAG      | DEFICIENCY)                                                      |                  | DATE       |
|           | SOC 11/21/16, v      | was reviewed. The            |                            |          | notified of referral immediately                                 | so               |            |
|           | clinical record in   | ncluded a referral form      |                            |          | an order can be obtained to m                                    |                  |            |
|           |                      | The clinical record          |                            |          | evaluation visit to assess patie                                 | ent              |            |
|           |                      |                              |                            |          | for appropriateness of home                                      |                  |            |
|           |                      | ee an initial assessment     |                            |          | health care needs and eligibilit                                 | y. If            |            |
|           | visit note within    | 48 hours of the referral.    |                            |          | it is determined patient is not                                  |                  |            |
|           |                      |                              |                            |          | appropriate for home health ca<br>or they refuse services, nurse | are              |            |
|           | 5. The clinical r    | ecord for patient #6,        |                            |          | must notify MD of this and                                       |                  |            |
|           |                      | as reviewed. The clinical    |                            |          | document on paperwork. (To                                       | be               |            |
|           | 1                    | evidence a referral form     |                            |          | done by 8/25/17 and be on-go                                     |                  |            |
|           |                      | nation note which            |                            |          | Director of Nursing/designee v                                   |                  |            |
|           |                      |                              |                            |          | be notified of all referrals                                     |                  |            |
|           |                      | the patient would be         |                            |          | immediately. Director/designed                                   | Э                |            |
|           | •                    | the hospital. The            |                            |          | will be responsible to track                                     |                  |            |
|           | clinical record fa   | ailed to evidence an         |                            |          | referrals to monitor for                                         |                  |            |
|           | initial assessmer    | nt visit note.               |                            |          | compliance with making initial                                   |                  |            |
|           |                      |                              |                            |          | assessment visit within time                                     |                  |            |
|           | 6 The clinical r     | record for patient #8,       |                            |          | frame or if it was determined                                    |                  |            |
|           |                      | •                            |                            |          | patient was not eligible for hon<br>care referral source/MD is   | ne               |            |
|           |                      | s reviewed. The clinical     |                            |          | notified. Director will be                                       |                  |            |
|           |                      | a referral form dated        |                            |          | responsible to monitor for                                       |                  |            |
|           | 5/25/16. The cl      | inical record failed to      |                            |          | compliance with initial                                          |                  |            |
|           | evidence an initi    | al assessment visit note     |                            |          | assessment visit being done                                      |                  |            |
|           | within 48 hours      | of the referral.             |                            |          | within forty-eight (48) hours. The                               | his              |            |
|           |                      |                              |                            |          | will be done by comparing date                                   | e of             |            |
|           | 7 The clinical r     | record for patient #9,       |                            |          | referral to date on initial                                      |                  |            |
|           |                      | -                            |                            |          | assessment visit. (To begin by                                   | ,                |            |
|           |                      | s reviewed. The clinical     |                            |          | 8/25/17)                                                         |                  |            |
|           |                      | a referral form dated        |                            |          | Director of Nursing/designee v                                   |                  |            |
|           | 6/9/16. The clin     | ical record failed to        |                            |          | be responsible to ensure there                                   | : IS             |            |
|           | evidence an initi    | al assessment visit note     |                            |          | a referral form completed all patients. Will ensure there is     |                  |            |
|           | within 48 hours      | of the referral.             |                            |          | documentation on referral form                                   | n if             |            |
|           |                      |                              |                            |          | patient is in hospital indicating                                |                  |            |
|           | Q During the er      | ntrance conference with      |                            |          | anticipated discharge date. All                                  |                  |            |
|           | _                    | ntrance conference with      |                            |          | referral forms to be audited by                                  |                  |            |
|           |                      | , the Interim Assistant      |                            |          | Director of Nursing/designee to                                  |                  |            |
|           |                      | ical Services and with       |                            |          | monitor for compliance.(To be                                    |                  |            |
|           | Employee A, the      | e Alternate Administrator    |                            |          | by 8/25/17)                                                      |                  |            |
|           | on 5/30/17 at 11     | :10 a.m. Employee A          |                            |          |                                                                  |                  |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 136 of 247

|                          | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                   |          | UILDING             | 00                                                                                                                     | COMPL<br>06/05/ | ETED                       |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|---------------------|------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------|
| NAME OF I                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                  | <u> </u> |                     | DDRESS, CITY, STATE, ZIP CODE 82ND ST STE 216                                                                          |                 | -                          |
| AT HOM                   | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ES LLC                                                                                                                                                                                                                                                                                           |          | INDIAN              | APOLIS, IN 46250                                                                                                       |                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                |          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE              | (X5)<br>COMPLETION<br>DATE |
|                          | included referral obtain prior authoronce provide A individual assessment made even when order patient's were not inappropriateness provide they carpotential clients  9. An undated provide the evaluated by determine the improvide they carpotential clients  1. Will be evaluated by determine the improvide they carpotential clients in support needs of clients, to determine the improvide they carpote the eight (48) hours of refereight (48) hours of refereight (48) hours of refereight (48) hours of refereight (48) hours of care date " | rolicy titled "Client ess" C- 140, indicated " ferred to the agency shall a Registered Nurse to amediate care and of the client; and for an ine eligibility for home of the initial assessment and within forty - eight for the client's return receipt of a signed and / client requested start |          |                     |                                                                                                                        |                 |                            |
| N 0484<br>Bldg. 00       | 410 IAC 17-12-2(g<br>Q A and performa<br>Rule 12 Sec. 2(g)<br>services shall mai                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | nce improvement All personnel providing                                                                                                                                                                                                                                                          |          |                     |                                                                                                                        |                 |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 137 of 247

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                | r ´ | JILDING             | onstruction <u>00</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE<br>COMPL<br><b>06/05</b> /                                         | ETED                       |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                         |     | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                       |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ΓΕ                                                                           | (X5)<br>COMPLETION<br>DATE |
|                          | appropriately comsupport the object The means of conresults shall be do record or minutes Based on record the agency failed case conferences of 8 active record of 10. (#2 - 9)  Findings included 1. A "60 day Cadated 4/6/17, was sheet provided.  A. Review of conference, the indicated "no nellost 6 lbs [pound documentation which indicated "med of wks [weeks], was change southern documentation which indicated "med of wks [weeks], was change southern documentation which indicated "med of wks [weeks], was change southern documentation which indicated "med of wks [weeks], was change southern documentation which indicated "med of wks [weeks], was change southern documentation which indicated "med of wks [weeks], was change southern documentation which indicated "med of wks [weeks], was change southern documentation which is the subject to the weeks of the wind was a subject to the weeks [weeks], was change southern documentation which is the weeks [weeks] was conference, the " | ase Conference" sheets as reviewed. No sign in  of patient #2 case 'Update / Comments" w meds [medications] / as]." No further was included.  of patient #3 case 'Update / Comments" changes, medset every 2 ants new doc [doctor]" No further was included.  of patient #5 case 'Update / Comments" anges." No further | N O | 484                 | Director of Nursing/designee vin-service nurses on properly documenting the 60 Day Conference. Documentation to include current disciplines, frequency, duration, tasks beir provided, progress towards stagoals – if not progressing then what changes need to be mad physical status, any concerns, names of any other medical agencies that are providing service, etc. (To be completed 8/25/17)  Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on properly documentithe 60 Day Conference.  Documentation to include curredisciplines, frequency, duration tasks being provided, progress towards stated goals – if not progressing then what change need to be made, physical state any concerns, names of any of medical agencies that are providing service, etc. (To beging by 8/25/17)  Director of Nursing/designee valudit 100% of case conference notes, until 100% compliance achieved, to monitor for compliance with proper | ong<br>ated<br>e,<br>by<br>on<br>ang<br>ent<br>n,<br>s<br>tus,<br>ther<br>in | 08/25/2017                 |

|               | IT OF DEFICIENCIES                  | X1) PROVIDER/SUPPLIER/CLIA                                | ľ     |               | NSTRUCTION                                                                                          | (X3) DATE SURVEY |                    |
|---------------|-------------------------------------|-----------------------------------------------------------|-------|---------------|-----------------------------------------------------------------------------------------------------|------------------|--------------------|
| AND PLAN      | OF CORRECTION                       | IDENTIFICATION NUMBER:                                    |       | ILDING        | 00                                                                                                  | COMPL            |                    |
|               |                                     | 15K064                                                    | B. WI | _             |                                                                                                     | 06/05/           | 2017               |
| NAME OF F     | PROVIDER OR SUPPLIER                |                                                           |       |               | ADDRESS, CITY, STATE, ZIP CODE                                                                      |                  |                    |
|               |                                     | TC 11 C                                                   |       |               | 82ND ST STE 216                                                                                     |                  |                    |
|               | E HEALTH SERVIC                     |                                                           |       |               | APOLIS, IN 46250                                                                                    |                  |                    |
| (X4) ID       |                                     | TATEMENT OF DEFICIENCIES                                  |       | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE                                  |                  | (X5)               |
| PREFIX<br>TAG | ``                                  | CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION) |       | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)                                                   | E                | COMPLETION<br>DATE |
|               |                                     |                                                           |       |               | documentation of case                                                                               |                  |                    |
|               | D. Review of                        | of patient #6 case                                        |       |               | conference. Once 100%                                                                               |                  |                    |
|               | conference, the "Update / Comments" |                                                           |       |               | compliance is achieved, Direct<br>of Nursing/designee will audit                                    | or               |                    |
|               | indicated Group                     | Home not checking on                                      |       |               | 25% of case conference notes                                                                        |                  |                    |
|               | -                                   | ney issues." No further                                   |       |               | monthly to monitor for complia                                                                      |                  |                    |
|               | documentation w                     |                                                           |       |               | with properly documenting                                                                           |                  |                    |
|               |                                     |                                                           |       |               | required information. (To begin 8/25/17)                                                            | ı by             |                    |
|               |                                     | of patient #7 case                                        |       |               | Discrete of No. 1 / 1 /                                                                             | .:11             |                    |
|               | · ·                                 | 'Update / Comments"                                       |       |               | Director of Nursing/designee we ensure there is a sign in sheet                                     |                  |                    |
|               |                                     | anges, 101!, can't get out                                |       |               | all participating staff to sign.(So                                                                 |                  |                    |
|               |                                     | further documentation                                     |       |               | Attachment B) (To be complete                                                                       |                  |                    |
|               | was included.                       |                                                           |       |               | by 8/25/17)                                                                                         |                  |                    |
|               |                                     | of patient #8 case<br>'Update / Comments''                |       |               | Director of Nursing/designee winstruct nurses that aides are to be involved in case conference      | 0                |                    |
|               | indicated "no chachair."            | anges - hoyer lift, shower                                |       |               | Aides will be given notice of who case conferences are being do and their input will be asked. (**) | nen<br>one       |                    |
|               | G. Review                           | of patient #9 case                                        |       |               | be completed by 8/25/17)                                                                            |                  |                    |
|               | conference, the "                   | 'Update / Comments"                                       |       |               | Director of Nursing will be                                                                         |                  |                    |
|               |                                     | anges, cath change e / o                                  |       |               | responsible for monitoring thes                                                                     |                  |                    |
|               | [every other] wk                    |                                                           |       |               | corrective actions to ensure the<br>this deficiency is corrected and                                |                  |                    |
|               | documentation w                     | vas included.                                             |       |               | will not recur.                                                                                     | •                |                    |
|               | 2. A 60 day Cas                     | e Conference sheets                                       |       |               |                                                                                                     |                  |                    |
|               | dated 5/18/17, w                    | as reviewed. The sign in                                  |       |               |                                                                                                     |                  |                    |
|               | sheet included pe                   | ersonnel from medical                                     |       |               |                                                                                                     |                  |                    |
|               | records, 2 schedu                   | ulers, quality assurance,                                 |       |               |                                                                                                     |                  |                    |
|               | Employee A, the                     | Alternate                                                 |       |               |                                                                                                     |                  |                    |
|               | Administrator, E                    | imployee B, the Director                                  |       |               |                                                                                                     |                  |                    |
|               |                                     | ces, and Employee C, the                                  |       |               |                                                                                                     |                  |                    |
|               | Interim Assistan                    | t Director of Clinical                                    |       |               |                                                                                                     |                  |                    |
|               | Services as Case                    | Managers. The sign in                                     |       |               |                                                                                                     |                  |                    |
|               | sheet failed to ev                  | vidence the attendance of                                 |       |               |                                                                                                     |                  |                    |

|                          | OF CORRECTION                                          | IDENTIFICATION NUMBER:  15K064                                                                      |   | UILDING             | 00                                                                                                            | COMPL<br>06/05 | ETED                       |
|--------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---|---------------------|---------------------------------------------------------------------------------------------------------------|----------------|----------------------------|
| NAME OF I                | PROVIDER OR SUPPLIEF                                   |                                                                                                     | • |                     | DDRESS, CITY, STATE, ZIP CODE                                                                                 |                |                            |
| AT HOM                   | E HEALTH SERVIC                                        | ES LLC                                                                                              |   |                     | 82ND ST STE 216<br>APOLIS, IN 46250                                                                           |                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                         | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | NTE .          | (X5)<br>COMPLETION<br>DATE |
|                          | the home health                                        | aides.                                                                                              |   |                     |                                                                                                               |                |                            |
|                          | conference, the '                                      | of patient #2 case 'Update / Comments" ng new." No further was included.                            |   |                     |                                                                                                               |                |                            |
|                          | conference, the '                                      | of patient #3 case 'Update / Comments" next week." No further was included.                         |   |                     |                                                                                                               |                |                            |
|                          | conference, the 'indicated 'deteri<br>wheelchair, unal | of patient #4 case 'Update / Comments" orated since 4/25, ble to ambulate." No tation was included. |   |                     |                                                                                                               |                |                            |
|                          | conference, the '                                      | of patient #5 case 'Update / Comments" anges." No further was included.                             |   |                     |                                                                                                               |                |                            |
|                          | conference, the '                                      | of patient #6 case 'Update / Comments" newal." No further was included.                             |   |                     |                                                                                                               |                |                            |
|                          | conference, the '                                      | of patient #7 case 'Update / Comments" fall." No further was included.                              |   |                     |                                                                                                               |                |                            |
|                          | G. Review                                              | of patient #8 case                                                                                  |   |                     |                                                                                                               |                |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 140 of 247

|                          | OF CORRECTION                                                                    | IDENTIFICATION NUMBER:  15K064                                                                              | ľ í                                              | UILDING             | 00                                                                                                            | COMPL<br>06/05/ | ETED                       |
|--------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------|-----------------|----------------------------|
| NAME OF I                | PROVIDER OR SUPPLIER                                                             |                                                                                                             | •                                                |                     | ADDRESS, CITY, STATE, ZIP CODE                                                                                | •               |                            |
| AT HOM                   | E HEALTH SERVIC                                                                  | ES LLC                                                                                                      | 6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                     |                                                                                                               |                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                           |                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ιΤΕ             | (X5)<br>COMPLETION<br>DATE |
|                          | · · · · · · · · · · · · · · · · · · ·                                            | 'Update / Comments"<br>anges." No further<br>vas included.                                                  |                                                  |                     |                                                                                                               |                 |                            |
|                          |                                                                                  | of patient #9 case<br>'Update / Comments"                                                                   |                                                  |                     |                                                                                                               |                 |                            |
|                          | evidence the effe                                                                | conference failed to ective interchange in ing, interventions, and goals.                                   |                                                  |                     |                                                                                                               |                 |                            |
|                          |                                                                                  | and Employee C had no tion to the above findings p.m.                                                       |                                                  |                     |                                                                                                               |                 |                            |
|                          | further informati                                                                | the Alternate and Employee B, had no on or documentation by ace on 6/5/17 at 3:50 p.m.                      |                                                  |                     |                                                                                                               |                 |                            |
|                          | 360, indicated "I<br>this agency to en<br>interchange, repo<br>of care and infor | f Client Services" C - t shall be the policy of sure effective orting and coordination mation provided by   |                                                  |                     |                                                                                                               |                 |                            |
|                          | establish interch<br>coordinated eval<br>disciplines invol                       | be held as necessary to ange, reporting, and uation between all ved in the client's care nferences shall be |                                                  |                     |                                                                                                               |                 |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 141 of 247

|          |                                                                                                                                                                                                                       | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                              | <b>1</b> ′ |         | ONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X3) DATE S                |            |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------|
| AND PLAN | OF CORRECTION                                                                                                                                                                                                         | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                  |            | JILDING | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | COMPL                      |            |
|          |                                                                                                                                                                                                                       | 15K064                                                                                                                                                                                                                                                                                  | B. Wl      | NG      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 06/05/                     | 2017       |
|          | ROVIDER OR SUPPLIER                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                         |            | 6525 E  | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            |            |
| (X4) ID  | SUMMARY S                                                                                                                                                                                                             | FATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                |            | ID      | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            | (X5)       |
| PREFIX   | (EACH DEFICIEN                                                                                                                                                                                                        | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                             |            | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ΓE                         | COMPLETION |
| TAG      | REGULATORY OR                                                                                                                                                                                                         | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                            |            | TAG     | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                            | DATE       |
| N 0486   | and progress. A                                                                                                                                                                                                       | nluate the client's status<br>ny problems will be<br>action plan developed                                                                                                                                                                                                              |            |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |            |
|          | Q A and performa                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                         |            |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |            |
| Bldg. 00 | Rule 12 Sec. 2(h) shall coordinate its or social service p patient.  Based on record the agency failed efforts were coordinate the alth proving patients in 5 out reviewed of patients.                               | The home health agency is services with other health providers serving the review and interview, I to ensure that their redinated effectively with reders serving their of 5 active records ents receiving outside uple of 10. (#5, 6, 7, 8)                                            | N 0        | 486     | Director of Nursing will in-servinurses on coordinating care wall medical agencies involved patient. Training will include documenting name of agency, name/title of person spoke with payer, discipline(s), frequency, duration and tasks to be provid (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientatiof newly hired nurses includes                                                                                                                                                                                       | ith<br>with<br>n,<br>ded.  | 08/25/2017 |
|          | 1. The clinical re 11/21/16, was re plan of care for t 5/20/17 to 7/18/1 indicated the pat physical, occupa therapy with a M the patient reside 24 hour supervis failed to evidenc coordinated serv agency and failed | ecord of patient #5, SOC<br>viewed and included a<br>he certification period of<br>17. The plan of care<br>ient was receiving<br>tional, and speech<br>dedicare agency and that<br>ed in a group home with<br>ion. The clinical record<br>that the agency had<br>ices with the Medicare |            |         | training on coordinating care wall medical agencies involved to patient. Training will include documenting name of agency, name/title of person spoke with payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/1 Director of Nursing/designee waudit 100% of admissions, resumptions and re-certificatio to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17) Director of Nursing will in-servinursing staff on requirement to notify MD of a patient's discha | vith with  n,  7) vill  ns |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 142 of 247

| STATEMEN  | NT OF DEFICIENCIES                    | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |          | ONSTRUCTION                                                            | (X3) DATE SURVEY |           |
|-----------|---------------------------------------|------------------------------|----------------------------|----------|------------------------------------------------------------------------|------------------|-----------|
| AND PLAN  | OF CORRECTION                         | IDENTIFICATION NUMBER:       | A. BU                      | JILDING  | 00                                                                     | COMPLETED        |           |
|           |                                       | 15K064                       | B. W                       | ING      |                                                                        | 06/05/201        | 17        |
|           |                                       |                              |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                         |                  |           |
| NAME OF I | PROVIDER OR SUPPLIEF                  | 8                            |                            |          | 82ND ST STE 216                                                        |                  |           |
| AT HOM    | E HEALTH SERVIC                       | CES LLC                      |                            |          | APOLIS, IN 46250                                                       |                  |           |
| (X4) ID   | SUMMARY S                             | TATEMENT OF DEFICIENCIES     |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                          |                  | (X5)      |
| PREFIX    | (EACH DEFICIEN                        | ICY MUST BE PRECEDED BY FULL |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | re CO            | OMPLETION |
| TAG       | REGULATORY OR                         | LSC IDENTIFYING INFORMATION) |                            | TAG      | DEFICIENCY)                                                            |                  | DATE      |
|           | expectations / de                     | elineation of duties with    |                            |          | notify patient/caregiver of                                            |                  |           |
|           | the home health                       | agency.                      |                            |          | discharge at least fifteen (15)                                        |                  |           |
|           |                                       |                              |                            |          | days before discharge and                                              |                  |           |
|           | 2 The clinical r                      | record of patient #6, SOC    |                            |          | notifying any other agency involved in patient's care of               |                  |           |
|           |                                       | riewed and included a        |                            |          | upcoming discharge of patient                                          |                  |           |
|           |                                       |                              |                            |          | from agency. Nurses to docum                                           |                  |           |
|           | _                                     | the certification period of  |                            |          | these conversations in patient'                                        |                  |           |
|           |                                       | 17, with orders for skilled  |                            |          | chart. (To be completed by                                             |                  |           |
|           | _                                     | a week and home health       |                            |          | 8/25/17)                                                               |                  |           |
|           | aide services 7 d                     | lays a week.                 |                            |          | Director of Nursing will be                                            |                  |           |
|           |                                       |                              |                            |          | responsible to ensure orientati                                        |                  |           |
|           | A. During a                           | home visit on 6/2/17 at      |                            |          | of newly hired nurses includes training on requirement to noti         |                  |           |
|           | 9:30 a.m., the pa                     | atient was observed to       |                            |          | MD of a patient's discharge, no                                        | •                |           |
|           |                                       | ome. The clinical record     |                            |          | patient/caregiver of discharge                                         |                  |           |
|           | • •                                   | te that the agency had       |                            |          | least fifteen (15) days before                                         |                  |           |
|           |                                       | rices with the group home    |                            |          | discharge and notifying any ot                                         |                  |           |
|           |                                       | ns / delineation of duties   |                            |          | agency involved in patient's ca                                        |                  |           |
|           | _                                     |                              |                            |          | of upcoming discharge of patie from agency. Nurses to docum            |                  |           |
|           | with the home h                       | earm agency.                 |                            |          | these conversations in patient                                         |                  |           |
|           |                                       |                              |                            |          | chart. (To begin by 8/25/17)                                           |                  |           |
|           |                                       | record for patient #7,       |                            |          | Director of Nursing/designee v                                         | /ill             |           |
|           |                                       | ncluded a plan of care for   |                            |          | audit 100% of discharges to                                            |                  |           |
|           | the certification                     | period of 4/9/17 to          |                            |          | ensure compliance with notifyi                                         | ng               |           |
|           | 6/7/17, with ord                      | ers for home health aide     |                            |          | MD of upcoming discharge,                                              | .                |           |
|           | services up to 6                      | hours per day, 7 days a      |                            |          | notifying patient of discharge a least fifteen (15) days before        | II               |           |
|           | week.                                 |                              |                            |          | discharge and notifying other                                          |                  |           |
|           |                                       |                              |                            |          | agencies involved in patient's                                         |                  |           |
|           | A Review                              | of a recertification         |                            |          | care of patient's upcoming                                             |                  |           |
|           |                                       | assessment dated 4/7/17,     |                            |          | discharge from agency. (To be                                          | gin              |           |
|           | _                                     | 1 Services" narrative        |                            |          | 8/25/17)                                                               |                  |           |
|           | section indicated                     |                              |                            |          | The Director of Nursing will be<br>responsible for monitoring thes     |                  |           |
|           |                                       | -                            |                            |          | corrective actions to ensure th                                        |                  |           |
|           | _                                     | health services with a       |                            |          | this deficiency is corrected and                                       |                  |           |
|           | Medicare agency for wound treatments. |                              |                            |          | will not recur.                                                        |                  |           |
|           | •                                     | sive assessment failed to    |                            |          |                                                                        |                  |           |
|           |                                       | nplete skin assessment,      |                            |          |                                                                        |                  |           |
|           | including visual                      | site, of the patient's       |                            |          |                                                                        |                  |           |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 143 of 247

|                          | NT OF DEFICIENCIES  OF CORRECTION                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                            | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | DNSTRUCTION  00                                                                                                   | (X3) DATE S<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIEI                                                                                                  |                                                                                                                                                                                                                     | 6525 E                                     | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                             | •                              |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                        | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                             | (X5)<br>COMPLETION<br>DATE |
|                          |                                                                                                                       | inical record failed to empted coordination with ency.                                                                                                                                                              |                                            |                                                                                                                   |                                |                            |
|                          | 5/2/17, indicated receiving home different Medica treatment of wor failed to evidence                                 | unication log dated I that the patient was health services with a are agency for the unds. The clinical record the that the agency had rices with the correct y.                                                    |                                            |                                                                                                                   |                                |                            |
|                          | SOC 8/3/16, inc<br>the certification<br>5/29/17, with or<br>aide up to 8 hou<br>The plan of care<br>receiving skilled | record for patient #8,<br>luded a plan of care for<br>period of 3/31/17 to<br>ders for a home health<br>rs a day, 7 days a week.<br>indicated the patient was<br>I nursing and home health<br>th a Medicare agency. |                                            |                                                                                                                   |                                |                            |
|                          | the "Professional indicated the part health services 3 Medicare agency                                                | of the OASIS start of care assessment dated 8/3/16, I Services" narrative tient was receiving home a times a week through a sy for management of set to the patient's right arm                                     |                                            |                                                                                                                   |                                |                            |
|                          | comprehensive                                                                                                         | of the OASIS<br>recertification assessment<br>/30/17, the "Professional                                                                                                                                             |                                            |                                                                                                                   |                                |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 144 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING OO COMPLETED |      |               |                                                                    |        |                    |
|------------------------------------------------------|----------------------|-----------------------------------------------------------------------|------|---------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:                                                |      | JILDING       | 00                                                                 |        |                    |
|                                                      |                      | 15K064                                                                | B. W | ING           |                                                                    | 06/05/ | 2017               |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | <b>\</b>                                                              |      |               | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
| AT 110M                                              |                      | 250110                                                                |      |               | 82ND ST STE 216                                                    |        |                    |
|                                                      | E HEALTH SERVIC      |                                                                       |      |               | APOLIS, IN 46250                                                   |        |                    |
| (X4) ID<br>PREFIX                                    |                      | TATEMENT OF DEFICIENCIES                                              |      | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| TAG                                                  | `                    | ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)           |      | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)                    | TE     | COMPLETION<br>DATE |
|                                                      |                      | ive indicated the patient                                             |      | 0             |                                                                    |        | 5.112              |
|                                                      |                      | tilled nursing and home                                               |      |               |                                                                    |        |                    |
|                                                      | _                    | ces through a Medicare                                                |      |               |                                                                    |        |                    |
|                                                      |                      | nical record failed to                                                |      |               |                                                                    |        |                    |
|                                                      |                      | e agency had coordinated                                              |      |               |                                                                    |        |                    |
|                                                      |                      | e Medicare agency.                                                    |      |               |                                                                    |        |                    |
|                                                      |                      |                                                                       |      |               |                                                                    |        |                    |
|                                                      | 5. The clinical r    | record for #10, SOC (start                                            |      |               |                                                                    |        |                    |
|                                                      |                      | , was reviewed and                                                    |      |               |                                                                    |        |                    |
|                                                      | included a plan      |                                                                       |      |               |                                                                    |        |                    |
|                                                      | _                    | 5/7/17 to 5/5/17, with                                                |      |               |                                                                    |        |                    |
|                                                      |                      | health aide services up to                                            |      |               |                                                                    |        |                    |
|                                                      |                      | lays a week to assist with                                            |      |               |                                                                    |        |                    |
|                                                      | 1                    | athing, dressing, activities                                          |      |               |                                                                    |        |                    |
|                                                      |                      | neal prep, medication                                                 |      |               |                                                                    |        |                    |
|                                                      | 1                    | ght housekeeping per                                                  |      |               |                                                                    |        |                    |
|                                                      | care plan.           |                                                                       |      |               |                                                                    |        |                    |
|                                                      | _                    |                                                                       |      |               |                                                                    |        |                    |
|                                                      | A. The clin          | ical record evidenced a                                               |      |               |                                                                    |        |                    |
|                                                      | discharge OASI       | S discharge assessment                                                |      |               |                                                                    |        |                    |
|                                                      | dated 4/2/17. Th     | ne clinical record failed                                             |      |               |                                                                    |        |                    |
|                                                      | to evidenced tha     | t the attending physician                                             |      |               |                                                                    |        |                    |
|                                                      | had been notified    | d in advance of the                                                   |      |               |                                                                    |        |                    |
|                                                      | patient's unsched    | duled discharge, the                                                  |      |               |                                                                    |        |                    |
|                                                      | patient had been     | informed in advance of                                                |      |               |                                                                    |        |                    |
|                                                      | the discharge an     | d failed to provide                                                   |      |               |                                                                    |        |                    |
|                                                      | documentation is     | n regards notifying the                                               |      |               |                                                                    |        |                    |
|                                                      | other home healt     | th agency and verifying                                               |      |               |                                                                    |        |                    |
|                                                      | the type of servi    | ces being provided.                                                   |      |               |                                                                    |        |                    |
|                                                      |                      |                                                                       |      |               |                                                                    |        |                    |
|                                                      | B. An inter          | view with the Employee                                                |      |               |                                                                    |        |                    |
|                                                      | C, Interim Assis     | tant Director of Clinical                                             |      |               |                                                                    |        |                    |
|                                                      | Services, on 5/3     | 1/17 at 2:30 p.m., the                                                |      |               |                                                                    |        |                    |
|                                                      | employee indica      | ted the patient notified                                              |      |               |                                                                    |        |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 145 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                | ONSTRUCTION  00                                                                           | (X3) DATE S'<br>COMPLE<br>06/05/2                                                                                      | TED |                            |  |  |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----|----------------------------|--|--|
|                                                                                                            | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                                        |     |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                         | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE  | (X5)<br>COMPLETION<br>DATE |  |  |
|                                                                                                            | health agency was<br>Health Services of<br>patient. The employer of the control of the | /17 at 2:30 p.m.,                                                                                                                         |                                                                                           |                                                                                                                        |     |                            |  |  |
|                                                                                                            | any further docu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | s not unable to provide mentation upon request.                                                                                           |                                                                                           |                                                                                                                        |     |                            |  |  |
|                                                                                                            | Director of Clini<br>Employee C indi<br>the care coordina<br>acknowledged th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | cated they are aware of ation component and a problem ion of all conversations                                                            |                                                                                           |                                                                                                                        |     |                            |  |  |
|                                                                                                            | 360, indicated "I this agency to en interchange, repo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Client Services" C - t shall be the policy of sure effective orting and coordination mation provided by                                   |                                                                                           |                                                                                                                        |     |                            |  |  |
| N 0494<br>Bldg. 00                                                                                         | be informed of the effective means of home health agen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | The patient or the resentative has the right to patient's rights through a communication. The cy must protect and ise of these rights and |                                                                                           |                                                                                                                        |     |                            |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 146 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE |       | SURVEY          |                                                                    |       |            |
|------------------------------------------------------|-----------------------|--------------------------------------|-------|-----------------|--------------------------------------------------------------------|-------|------------|
| AND PLAN                                             | OF CORRECTION         | IDENTIFICATION NUMBER:               | A. BU | JILDING         | 00                                                                 | COMPL | ETED       |
|                                                      |                       | 15K064                               | B. W  | B. WING 06/05/2 |                                                                    |       | /2017      |
|                                                      |                       |                                      |       | STREET          | ADDRESS, CITY, STATE, ZIP CODE                                     |       |            |
| NAME OF P                                            | ROVIDER OR SUPPLIER   | 8                                    |       |                 | 82ND ST STE 216                                                    |       |            |
| АТ НОМІ                                              | E HEALTH SERVIC       | CESTIC                               |       |                 | IAPOLIS, IN 46250                                                  |       |            |
|                                                      |                       |                                      | _     |                 | 1                                                                  |       |            |
| (X4) ID                                              |                       | TATEMENT OF DEFICIENCIES             |       | ID              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |       | (X5)       |
| PREFIX                                               | `                     | ICY MUST BE PRECEDED BY FULL         |       | PREFIX          | CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)                    | TE    | COMPLETION |
| TAG                                                  |                       | LSC IDENTIFYING INFORMATION)         | -     | TAG             | DEFICIENCY)                                                        |       | DATE       |
|                                                      | of the patient's rig  | atient with a written notice         |       |                 |                                                                    |       |            |
|                                                      |                       | furnishing care to the               |       |                 |                                                                    |       |            |
|                                                      | patient; or           | rarmorming care to the               |       |                 |                                                                    |       |            |
|                                                      | •                     | ial evaluation visit before          |       |                 |                                                                    |       |            |
|                                                      | the initiation of tre | atment.                              |       |                 |                                                                    |       |            |
|                                                      |                       | umentation showing that it           |       |                 |                                                                    |       |            |
|                                                      | •                     | the requirements of this             |       |                 |                                                                    |       |            |
|                                                      | section.              |                                      | 1,10  | 10.1            | Director of Nursing/designee v                                     | vill  | 00/05/0017 |
|                                                      |                       | review and interview,                | N 0   | 494             | in-service all nursing staff on t                                  |       | 08/25/2017 |
|                                                      | the agency failed     |                                      |       |                 | need to provide patient/caregi                                     |       |            |
|                                                      |                       | hat it had provided a                |       |                 | with a copy of Patient Rights.                                     |       |            |
|                                                      | •                     | notice of patient rights             |       |                 | (Complete 8/25/17)                                                 |       |            |
|                                                      | in 1 out of 1 reco    | ord reviewed of a patient            |       |                 | Director of Nursing will be                                        |       |            |
|                                                      | readmitted to ser     | rvices in a sample of 10.            |       |                 | responsible to ensure orientati                                    |       |            |
|                                                      | (#6)                  |                                      |       |                 | of newly hired nurses includes training on the need to provide     |       |            |
|                                                      |                       |                                      |       |                 | patient/caregiver with a copy of                                   |       |            |
|                                                      | Findings include      | ··                                   |       |                 | Patient Rights. (To begin by                                       | •     |            |
|                                                      | i mamga maraa         | •                                    |       |                 | 8/25/17)                                                           |       |            |
|                                                      | 1 The clinical r      | record for patient #6,               |       |                 | Director of Nursing/designee v                                     | vill  |            |
|                                                      |                       | as reviewed. The clinical            |       |                 | audit 100% of Admissions to                                        |       |            |
|                                                      | ,                     | evidence documentation               |       |                 | ensure compliance with documentation indicating                    |       |            |
|                                                      |                       |                                      |       |                 | patient/caregiver received cop                                     | v of  |            |
|                                                      | •                     | ad been provided with a              |       |                 | Patient Rights. After 100%                                         | y Oi  |            |
|                                                      | written notice of     | patient rights.                      |       |                 | compliance is achieved, Direc                                      | tor   |            |
|                                                      |                       |                                      |       |                 | of Nursing/designee will audit                                     |       |            |
|                                                      | A. The Dire           | ector of Clinical Services           |       |                 | 25% of admissions monthly to                                       |       |            |
|                                                      | was interviewed       | on 6/5/17 at 9:45 a.m.               |       |                 | monitor compliance with                                            |       |            |
|                                                      | and indicated the     | e patient's certification            |       |                 | documenting patient/caregiver received copy of Patient Right       |       |            |
|                                                      |                       | ring a hospitalization and           |       |                 | (To begin by 8/25/17)                                              | o.    |            |
|                                                      |                       | told by their consultant             |       |                 | Director of Nursing/designee v                                     | vill  |            |
|                                                      |                       | ion paperwork did not                |       |                 | train nursing staff on need to                                     |       |            |
|                                                      |                       | ded or signatures                    |       |                 | readmit patient if their certifica                                 |       |            |
|                                                      | obtained upon re      | •                                    |       |                 | period ends while hospitalized                                     |       |            |
|                                                      | obtained upon te      | Laumissium.                          |       |                 | (To be done by 8/25/17)                                            |       |            |
|                                                      |                       | 1: 1:101:                            |       |                 | The Director of Nursing will be responsible for monitoring the:    |       |            |
|                                                      | •                     | olicy titled "Client                 |       |                 | corrective actions to ensure th                                    |       |            |
|                                                      | Admission Proce       | ess" C- 140 indicated "              |       |                 | Concouve doublis to crisule til                                    | .0    | l          |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 147 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CC<br>A. BUILDING<br>B. WING                                                                                                                                      | onstruction  00                                                                           | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                  |                      |  |  |  |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--|--|--|
|                                                                                                            | ROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |                                                                                                                                                                        |                      |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                               | ID<br>PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)                                                | (X5) COMPLETION DATE |  |  |  |
|                                                                                                            | privacy rights and practices, and obdisclose protecte treatment, paymed operations. Provide with a copy and a Home Care Bill of Responsibilities, filing a complaint Statement of Privicellection and training the alth care information client's signature Agreement, Homand other forms and | and the procedures for at. This includes the vacy Rights related to the ansmission of personal mation Obtain the on the Service are Care Bill of Rights, required by the agency |                                                                                           | deficiency is corrected and will not recur.                                                                                                                            |                      |  |  |  |
| N 0504<br>Bldg. 00                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | atient has the right to<br>rights as a patient of the                                                                                                                           |                                                                                           |                                                                                                                                                                        |                      |  |  |  |
|                                                                                                            | (2) The patient had following: (D) Be informed a furnished, and of a be furnished as following. (i) The home heat the patient in advarsary (AA) disciplines the (BB) frequency of furnished.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | as the right to the about the care to be any changes in the care to lows: Ith agency shall advise nce of the: nat will furnish care; and f visits proposed to be                |                                                                                           |                                                                                                                                                                        |                      |  |  |  |
|                                                                                                            | the agency failed<br>and / or caregive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | review and interview, to ensure the patient r were informed in sciplines that would                                                                                             | N 0504                                                                                    | Director of Nursing will in-servi<br>nursing staff on documenting,<br>time of admission, that<br>patient/caregiver was notified of<br>disciplines to be provided, type | at of                |  |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 148 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                        | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |       |          | SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |            |
|------------------------------------------------------|----------------------------------------|--------------------------------------------|-------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                          | IDENTIFICATION NUMBER:                     | A. BU | JILDING  | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | COMPL  | ETED       |
|                                                      |                                        | 15K064                                     | B. W  | ING      | <del></del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 06/05/ | 2017       |
|                                                      |                                        |                                            |       | STREET / | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                   | ₹                                          |       | 1        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
| AT LIONA                                             |                                        | 250110                                     |       |          | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
| AT HOM                                               | E HEALTH SERVIC                        | JES LLC                                    |       | INDIAN   | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
| (X4) ID                                              | SUMMARY S                              | TATEMENT OF DEFICIENCIES                   |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                         | ICY MUST BE PRECEDED BY FULL               |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE     | COMPLETION |
| TAG                                                  | REGULATORY OR                          | LSC IDENTIFYING INFORMATION)               |       | TAG      | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        | DATE       |
|                                                      | furnish care, the                      | type of care to be                         |       |          | care to be provided, and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |            |
|                                                      | provided, the an                       | ticipated frequency /                      |       |          | frequency/duration of visits. (T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0      |            |
|                                                      | •                                      | s to be provided and of                    |       |          | be completed by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |            |
|                                                      |                                        | heir care in 2 out of 2                    |       |          | Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |            |
|                                                      |                                        |                                            |       |          | responsible to ensure orientati<br>of newly hired nurses includes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      |                                        | rds reviewed of changes                    |       |          | training on documenting, at time                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
|                                                      | ` `                                    | (0) and in 6 out of 6                      |       |          | of admission, that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |            |
|                                                      | admissions in 20                       | 116 and 2017 in a sample                   |       |          | patient/caregiver was notified                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of     |            |
|                                                      | of 10. (#3, 4, 5,                      | 6, 8 and 9)                                |       |          | disciplines to be provided, type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
|                                                      |                                        |                                            |       |          | care to be provided, and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |            |
|                                                      | Findings include                       | ·                                          |       |          | frequency/duration of visits. (T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | O      |            |
|                                                      | l mamgs morau                          | •                                          |       |          | begin by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      | 1 771 11                               |                                            |       |          | Director of Nursing/designee v                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | vill   |            |
|                                                      |                                        | record for patient #1 SOC                  |       |          | audit 100% of admissions to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |            |
|                                                      | ` ′                                    | 10/15, was reviewed and                    |       |          | ensure compliance with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |            |
|                                                      | included a writte                      | en plan of care for the                    |       |          | documenting, at time of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ·or    |            |
|                                                      | certification of 5                     | 5/9/15 to 7/7/15, with                     |       |          | admission, that patient/caregive was notified of disciplines to be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |            |
|                                                      | orders for home                        | health aide services up to                 |       |          | provided, type of care to be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5      |            |
|                                                      |                                        | days a week to assist                      |       |          | provided, and frequency/durati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ion    |            |
|                                                      |                                        | hygiene, transfers,                        |       |          | of visits. (To begin by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |            |
|                                                      |                                        |                                            |       |          | Director of Nursing will in-servi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |            |
|                                                      |                                        | nders, meal preparation /                  |       |          | nursing staff on requirement to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | )      |            |
|                                                      |                                        | housekeeping. The                          |       |          | notify MD of a patient's discha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | rge,   |            |
|                                                      | patient had a dia                      | gnosis of Multiple                         |       |          | notify patient/caregiver of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |            |
|                                                      | Sclerosis.                             |                                            |       |          | discharge at least fifteen (15)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      |                                        |                                            |       |          | days before discharge and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |            |
|                                                      | A Review                               | of the payroll time                        |       |          | notifying any other agency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        |            |
|                                                      |                                        | ne health aides were                       |       |          | involved in patient's care of<br>upcoming discharge of patient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
|                                                      | •                                      |                                            |       |          | from agency. Nurses to docum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |        |            |
|                                                      |                                        | es up from 5 to 7 hours a                  |       |          | these conversations in patient'                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | day                                    |                                            |       |          | chart. (To be completed by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Č      |            |
|                                                      |                                        |                                            |       |          | 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |            |
|                                                      | B. Review                              | of the FSSA (Family                        |       |          | Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |            |
|                                                      |                                        | Administration) Medicaid                   |       |          | responsible to ensure orientati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | paperwork dated 6/2/15, indicated the  |                                            |       |          | of newly hired nurses includes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |
|                                                      | ^ ^                                    | -                                          |       |          | training on requirement to noti                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |            |
|                                                      | patient's original prior authorization |                                            |       |          | MD of a patient's discharge, no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | •      |            |
|                                                      | -                                      | lified and that the                        |       |          | patient/caregiver of discharge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | at     |            |
|                                                      | I requested units v                    | were excessie based on                     |       |          | least fifteen (15) days before                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 149 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE |       |          | SURVEY                                                                                                  |          |            |
|------------------------------------------------------|----------------------|--------------------------------------------|-------|----------|---------------------------------------------------------------------------------------------------------|----------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:                     | A. BU | JILDING  | 00                                                                                                      | COMPL    | ETED       |
|                                                      |                      | 15K064                                     | B. W  | ING      |                                                                                                         | 06/05/   | 2017       |
|                                                      |                      |                                            |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                          | <u> </u> |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | t .                                        |       |          | 82ND ST STE 216                                                                                         |          |            |
| AT HOM                                               | E HEALTH SERVIC      | ES LLC                                     |       |          | APOLIS, IN 46250                                                                                        |          |            |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES                   |       | ID       | PROVIDENCE N. AN OF CORRECTION                                                                          |          | (X5)       |
| PREFIX                                               | (EACH DEFICIEN       | CY MUST BE PRECEDED BY FULL                |       | PREFIX   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE       | COMPLETION |
| TAG                                                  | REGULATORY OR        | LSC IDENTIFYING INFORMATION)               |       | TAG      | DEFICIENCY)                                                                                             | 16       | DATE       |
|                                                      | the medical doci     | imentation submitted.                      |       |          | discharge and notifying any ot                                                                          | her      |            |
|                                                      |                      |                                            |       |          | agency involved in patient's ca                                                                         |          |            |
|                                                      | C Review             | of the FSSA Medicaid                       |       |          | of upcoming discharge of patie                                                                          |          |            |
|                                                      |                      | 1 6/17/15, indicated the                   |       |          | from agency. Nurses to docum                                                                            |          |            |
|                                                      |                      |                                            |       |          | these conversations in patient chart. (To begin by 8/25/17)                                             | S        |            |
|                                                      | -                    | se the home health aide                    |       |          | Director of Nursing/designee v                                                                          | vill     |            |
|                                                      |                      | nied as medically not                      |       |          | audit 100% of discharges to                                                                             |          |            |
|                                                      | necessary.           |                                            |       |          | ensure compliance with notifyi<br>MD of upcoming discharge,                                             | ng       |            |
|                                                      | D. Review            | of the communications                      |       |          | notifying patient of discharge a                                                                        | at l     |            |
|                                                      |                      | /15, 6/18/15, 7/5/15 and                   |       |          | least fifteen (15) days before                                                                          |          |            |
|                                                      |                      | n 6/30/15, the agency                      |       |          | discharge and notifying other                                                                           |          |            |
|                                                      |                      |                                            |       |          | agencies involved in patient's                                                                          |          |            |
|                                                      |                      | te that the patient and / or               |       |          | care of patient's upcoming                                                                              |          |            |
|                                                      | _                    | formed of Medicaid's                       |       |          | discharge from agency. (To be by 8/25/17)                                                               | egin     |            |
|                                                      |                      | ease the home health aide                  |       |          | The Director of Nursing will                                                                            | he       |            |
|                                                      | hours, therefore,    | making a change in the                     |       |          | responsible for monitoring                                                                              | DC       |            |
|                                                      | agency's ability     | to service the patient.                    |       |          | these corrective actions to                                                                             |          |            |
|                                                      | 2 The clinical r     | ecord number 3, SOC                        |       |          | ensure that this deficiency i                                                                           |          |            |
|                                                      |                      |                                            |       |          | corrected and will not recur                                                                            |          |            |
|                                                      | ` ′                  | /28/16, was reviewed.                      |       |          |                                                                                                         |          |            |
|                                                      |                      | ord failed to evidence that                |       |          |                                                                                                         |          |            |
|                                                      | _                    | giver was informed and                     |       |          |                                                                                                         |          |            |
|                                                      | agreed in advance    | ce of the disciplines that                 |       |          |                                                                                                         |          |            |
|                                                      | will furnish care    | , the type of care to be                   |       |          |                                                                                                         |          |            |
|                                                      | provided, and th     | e anticipated frequency /                  |       |          |                                                                                                         |          |            |
|                                                      | duration of visits   | s to be provided.                          |       |          |                                                                                                         |          |            |
|                                                      |                      | •                                          |       |          |                                                                                                         |          |            |
|                                                      | 3 The clinical r     | ecord number 4, SOC                        |       |          |                                                                                                         |          |            |
|                                                      |                      | riewed. The clinical                       |       |          |                                                                                                         |          |            |
|                                                      |                      |                                            |       |          |                                                                                                         |          |            |
|                                                      |                      | evidence that the patient /                |       |          |                                                                                                         |          |            |
|                                                      |                      | formed and agreed in                       |       |          |                                                                                                         |          |            |
|                                                      |                      | isciplines that will                       |       |          |                                                                                                         |          |            |
|                                                      |                      | type of care to be                         |       |          |                                                                                                         |          |            |
|                                                      | provided, and th     | e anticipated frequency /                  |       |          |                                                                                                         |          |            |
|                                                      | duration of visits   | s to be provided.                          |       |          |                                                                                                         |          |            |

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                     | JILDING             | nstruction<br>00                                                                                                     | (X3) DATE<br>COMPL<br>06/05/ | ETED                       |  |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------|--|
|                          | PROVIDER OR SUPPLIEI                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                     |                                                                                                                      |                              |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | ATE                          | (X5)<br>COMPLETION<br>DATE |  |
|                          | soc 11/21/16, we clinical record fare patient / caregiver agreed in advance will furnish care provided, and the duration of visit.  5. The clinical record failed to caregiver was in advance of the duration of visit.  6. The clinical record failed to caregiver was in advance of the duration of visit.  6. The clinical record failed to caregiver was in advance of the duration of visit.  7. The clinical record failed to caregiver was in advance of the duration of visit. | record for patient #5, was reviewed. The ailed to evidence that the er was informed and ce of the disciplines that e, the type of care to be e anticipated frequency / s to be provided.  record for patient #6, as reviewed. The clinical evidence that the patient / formed and agreed in disciplines that will type of care to be e anticipated frequency / s to be provided.  record for patient #8, s reviewed. The clinical evidence that the patient / formed and agreed in disciplines that will type of care to be e anticipated frequency / s to be provided.  record for patient #9, s reviewed. The clinical evidence that the patient / formed and agreed in disciplines that will type of care to be e anticipated frequency / s to be provided. |                                                                                     |                     |                                                                                                                      |                              |                            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED |                |        |                                                                                        |        |            |
|------------------------------------------------------|----------------------|-----------------------------------------------------------------------|----------------|--------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER: 15K064                                         | A. BU<br>B. W. |        | 00                                                                                     | 06/05/ |            |
|                                                      |                      | 131(004                                                               | <i>D.</i> ,,,  |        | DDDEGG GUTY GTATE TID GODE                                                             | 00/03/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | 2                                                                     |                |        | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                      |        |            |
| AT HOM                                               | E HEALTH SERVIC      | CES LLC                                                               |                |        | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID                                              |                      | TATEMENT OF DEFICIENCIES                                              |                | ID     | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)       |
| PREFIX                                               | `                    | CY MUST BE PRECEDED BY FULL                                           |                | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION)                                          |                | TAG    | BEI ICIENCT)                                                                           |        | DATE       |
|                                                      | duration of visits   | e anticipated frequency / s to be provided.                           |                |        |                                                                                        |        |            |
|                                                      |                      | F                                                                     |                |        |                                                                                        |        |            |
|                                                      | 8. The clinical r    | record for #10, SOC (start                                            |                |        |                                                                                        |        |            |
|                                                      | of care) 5/11/16,    | , was reviewed and                                                    |                |        |                                                                                        |        |            |
|                                                      | included a plan      | of care for the                                                       |                |        |                                                                                        |        |            |
|                                                      | certification of 3   | 5/7/17 to 5/5/17, with                                                |                |        |                                                                                        |        |            |
|                                                      | orders for home      | health aide services up to                                            |                |        |                                                                                        |        |            |
|                                                      | 1 hour a day, 7 d    | lays a week to assist with                                            |                |        |                                                                                        |        |            |
|                                                      | personal care, ba    | athing, dressing, activities                                          |                |        |                                                                                        |        |            |
|                                                      | of daily living, n   | neal prep, medication                                                 |                |        |                                                                                        |        |            |
|                                                      | reminders and li     | ght housekeeping per                                                  |                |        |                                                                                        |        |            |
|                                                      | care plan.           |                                                                       |                |        |                                                                                        |        |            |
|                                                      | A 701 1:             |                                                                       |                |        |                                                                                        |        |            |
|                                                      |                      | ical record evidenced a                                               |                |        |                                                                                        |        |            |
|                                                      | _                    | S discharge assessment                                                |                |        |                                                                                        |        |            |
|                                                      |                      | ne clinical record failed                                             |                |        |                                                                                        |        |            |
|                                                      |                      | t the attending physician                                             |                |        |                                                                                        |        |            |
|                                                      |                      | d in advance of the                                                   |                |        |                                                                                        |        |            |
|                                                      | -                    | duled discharge, the                                                  |                |        |                                                                                        |        |            |
|                                                      | _                    | informed in advance of d failed to provide                            |                |        |                                                                                        |        |            |
|                                                      |                      | n regards notifying the                                               |                |        |                                                                                        |        |            |
|                                                      |                      | th agency and verifying                                               |                |        |                                                                                        |        |            |
|                                                      |                      | ces being provided.                                                   |                |        |                                                                                        |        |            |
|                                                      | and type of servi    | cos como provided.                                                    |                |        |                                                                                        |        |            |
|                                                      | B. An inter          | view with the Employee                                                |                |        |                                                                                        |        |            |
|                                                      |                      | tor of Clinical Services,                                             |                |        |                                                                                        |        |            |
|                                                      | -                    | 30 p.m., the employee                                                 |                |        |                                                                                        |        |            |
|                                                      |                      | tient notified the agency                                             |                |        |                                                                                        |        |            |
|                                                      | and indicated an     | other home health                                                     |                |        |                                                                                        |        |            |
|                                                      | agency was in th     | ne home. At Home                                                      |                |        |                                                                                        |        |            |
|                                                      | Health Services      | decided to discharge the                                              |                |        |                                                                                        |        |            |
|                                                      |                      | ployee indicated a 15 day                                             |                |        |                                                                                        |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 152 of 247

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                | UILDING | 00                  | COMPL<br>06/05/                                                                                               | ETED |                            |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------|---------------------------------------------------------------------------------------------------------------|------|----------------------------|
| NAME OF I                                                                      | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                     | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                              |      |                            |
| AT HOM                                                                         | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                     |                                                                                                               |      |                            |
| (X4) ID<br>PREFIX<br>TAG                                                       | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                              |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE   | (X5)<br>COMPLETION<br>DATE |
|                                                                                | C. On 5/31 Employee C was any further docu  9. Employee B. Services and Em Assistant Director had no further in documentation in findings on 6/2/1  10. Employee A Administrator ar further information the exit conference of the exit conference of the conference of | /17 at 2:30 p.m., so not unable to provide mentation upon request.  In the Director of Clinical aployee C, the Interimed for of Clinical Services, aformation or an relation to the above 17 at 4:00 p.m.  In the Alternate and Employee B, had no ion or documentation by accome 6/5/17 at 3:50 p.m.  In policy titled "Client ess" C- 140, indicated "an for services, are with the client / reasonable risk and / or ted with any procedure |         |                     |                                                                                                               |      |                            |
| N 0505<br>Bldg. 00                                                             | exercise his or he home health agen (2) The patient he following:  (D) Be informed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | patient has the right to rights as a patient of the locy as follows:                                                                                                                                                                                                                                                                                                                                                                           |         |                     |                                                                                                               |      |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 153 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION (X3) DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | SURVEY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                            |            |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                      | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A. BU   | ILDING | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | COMPL                                      | ETED       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | B. WING |        | 06/05/2017                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                            |            |
|                                                      | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | •       | 6525 E | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                            |            |
| (X4) ID                                              | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                                                                                          | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         | ID     | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                     | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | TE                                         | COMPLETION |
| TAG                                                  | REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                      | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         | TAG    | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | -                                          | DATE       |
|                                                      | the planning of the agency shall advis of the right to part following:  (AA) The care or (BB) Changes in Based on record the agency failed and / or caregive advance of the d furnish care, the provided, the and duration of visits any changes in the discharged record in care (#1 and 1 admissions in 20 of 10. (#3, 4, 5, Findings included a writted certification of 5 orders for home 10 hours a day 7 with grooming, I medication reminsetup, and light I | as the right to participate in the care. The home health see the patient in advance icipate in planning the streatment.  The treatment is the care or treatment.  The care or treatment is the care or treatment in the care or treatment in the care informed in the care informed in the care informed in the care informed in the care in a care to be the care to be the provided and of their care in 2 out of 2 and reviewed of changes (a) and in 6 out of 6 (b) 16 and 2017 in a sample (a), 8 and 9) | N 0.    | 505    | Director of Nursing will in-servinurses on need to notify patier caregiver if Medicaid decrease number of hours requested on the PA, obtain MD order for the hours approved by Medicaid a document in patient chart. (To done by 8/25/17) Director of Nursing/designee where the personsible to ensure orientation of newly hired nurs includes training on need to not patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain Morder for any decrease in the hours approved by Medicaid a document in patient chart. (To begin by 8/25/17) Director of Nursing/designee waudit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will ensure there is documentation patient/caregiver was notified the decrease and MD order was obtained for authorized frequency. Once 100% compliance is achieved, Director of Nursing/designee will audit, monthly, 25% of Medicaid authorizations received that | nt / es e e ind be vill es otify  d  of as | 08/25/2017 |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 154 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION   |       |          | (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |            |
|------------------------------------------------------|----------------------|------------------------------|-------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BU | JILDING  | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | COMPL              | ETED       |
|                                                      |                      | 15K064                       | B. W  | ING      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 06/05/             | 2017       |
|                                                      |                      |                              |       | CTDEET A | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | ₹                            |       |          | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
| AT 110N4                                             |                      | 250110                       |       |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
| AT HOW                                               | E HEALTH SERVIC      | ES LLC                       |       | INDIAN   | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |            |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES     |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                    | (X5)       |
| PREFIX                                               | (EACH DEFICIEN       | ICY MUST BE PRECEDED BY FULL |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE                 | COMPLETION |
| TAG                                                  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) |       | TAG      | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | DATE       |
|                                                      | A. Review            | of the payroll time          |       |          | month to ensure compliance w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |            |
|                                                      | records, the hom     | ne health aides were         |       |          | notifying patient/caregiver of a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | •                  |            |
|                                                      | · ·                  | es up from 5 to 7 hours a    |       |          | decrease in hours approved a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |            |
|                                                      | 1 .                  | es up from 5 to 7 flours u   |       |          | MD order obtained for authoriz                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |            |
|                                                      | day                  |                              |       |          | frequency. (To begin by 8/25/1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |            |
|                                                      |                      |                              |       |          | Director of Nursing will in-servinursing staff on documenting,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |            |
|                                                      | B. Review            | of the FSSA (Family          |       |          | time of admission, that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | al                 |            |
|                                                      | Social Service A     | dministration) Medicaid      |       |          | patient/caregiver was notified                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | of                 |            |
|                                                      | paperwork dated      | 1 6/2/15, indicated the      |       |          | disciplines to be provided, type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                    |            |
|                                                      | 1 ^ ^                | prior authorization          |       |          | care to be provided, and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | -                  |            |
|                                                      | ı ^                  | lified and that the          |       |          | frequency/duration of visits. (T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | O                  |            |
|                                                      |                      |                              |       |          | be completed by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                    |            |
|                                                      | *                    | were excessie based on       |       |          | Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |            |
|                                                      | the medical docu     | umentation submitted.        |       |          | responsible to ensure orientati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
|                                                      |                      |                              |       |          | of newly hired nurses includes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |            |
|                                                      | C. Review            | of the FSSA Medicaid         |       |          | training on documenting, at tin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ne                 |            |
|                                                      | nanerwork dated      | 1 6/17/15, indicated the     |       |          | of admission, that                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ,                  |            |
|                                                      |                      | se the home health aide      |       |          | patient/caregiver was notified of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    |            |
|                                                      |                      | enied as medically not       |       |          | disciplines to be provided, type care to be provided, and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <del>;</del> 01    |            |
|                                                      |                      | ined as medically not        |       |          | frequency/duration of visits. (T                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <u></u>            |            |
|                                                      | necessary.           |                              |       |          | begin by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | O                  |            |
|                                                      |                      |                              |       |          | Director of Nursing/designee w                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | vill               |            |
|                                                      | D. Review            | of the communications        |       |          | audit 100% of admissions to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |            |
|                                                      | notes dated 6/15     | /15, 6/18/15, 7/5/15 and     |       |          | ensure compliance with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |            |
|                                                      |                      | n 6/30/15, the agency        |       |          | documenting, at time of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    |            |
|                                                      | _                    | that the patient and / or    |       |          | admission, that patient/caregiv                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
|                                                      |                      | formed of Medicaid's         |       |          | was notified of disciplines to be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | е                  |            |
|                                                      | ~                    |                              |       |          | provided, type of care to be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                    |            |
|                                                      |                      | ease the home health aide    |       |          | provided, and frequency/durat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                    |            |
|                                                      | hours, therefore,    | making a change in the       |       |          | of visits. (To begin by 8/25/17) Director of Nursing will in-servi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                    |            |
|                                                      | agency's ability     | to service the patient.      |       |          | nursing staff on requirement to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
|                                                      |                      |                              |       |          | notify MD of a patient's discha                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
|                                                      | 2 The clinical r     | record number 3, SOC         |       |          | notify patient/caregiver of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | . <del>g</del> = , |            |
|                                                      |                      | /28/16, was reviewed.        |       |          | discharge at least fifteen (15)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |            |
|                                                      | , ,                  |                              |       |          | days before discharge and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |            |
|                                                      |                      | ord failed to evidence that  |       |          | notifying any other agency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |            |
|                                                      | *                    | egiver was informed and      |       |          | involved in patient's care of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                    |            |
|                                                      | agreed in advance    | ce of the disciplines that   |       |          | upcoming discharge of patient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                    |            |
|                                                      | will furnish care    | , the type of care to be     |       |          | from agency. Nurses to docum                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | nent               |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 155 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | r í                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | JILDING | onstruction <u>00</u> | (X3) DATE<br>COMPL<br><b>06/05</b> /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ETED                                                                      |                            |
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| NAME OF I                                                                                                  | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | -       |                       | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                            |
| AT HOM                                                                                                     | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                       | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                           |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TE                                                                        | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            | provided, and the duration of visits  3. The clinical research failed to exaregiver was in advance of the defurnish care, the provided, and the duration of visits  4. The clinical respective agreed in advance will furnish care provided, and the duration of visits  5. The clinical resord failed to exaregiver was in advance of the defurnish care, the provided, and the duration of visits  5. The clinical resord failed to exaregiver was in advance of the defurnish care, the provided, and the duration of visits  6. The clinical resord failed to exaregive the provided, and the duration of visits  6. The clinical resord failed to exaregive the provided, and the duration of visits  6. The clinical resord failed to exaregive the provided, and the duration of visits | e anticipated frequency / s to be provided.  ecord number 4, SOC iewed. The clinical evidence that the patient / formed and agreed in isciplines that will type of care to be e anticipated frequency / s to be provided.  ecord for patient #5, was reviewed. The niled to evidence that the er was informed and ee of the disciplines that the type of care to be e anticipated frequency / s to be provided.  ecord for patient #6, as reviewed. The clinical evidence that the patient / formed and agreed in isciplines that will type of care to be e anticipated frequency / |         |                       | these conversations in patient chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientat of newly hired nurses includes training on requirement to not MD of a patient's discharge, n patient/caregiver of discharge least fifteen (15) days before discharge and notifying any of agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient chart. (To begin by 8/25/17) Director of Nursing/designee of audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge, notifying patient of discharge aleast fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To be by 8/25/17) Director of Nursing will in-serve nursing staff on documenting, time of admission, that patient/caregiver was notified disciplines to be provided, and frequency/duration of visits. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientate of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified disciplines to be provided, typical completed by 8/25/17) Director of Nursing will be responsible to ensure orientate of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified disciplines to be provided, typical completed by 8/25/17) | ion ify otify at ther are ent nent ing at egin ice at of e of o ion o one |                            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULT<br>A. BUILI<br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | DING | NSTRUCTION  00    | (X3) DATE :<br>COMPL<br>06/05/                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ETED                             |                            |
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|                                                                                                            | PROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 6    | 6525 E 8          | DDRESS, CITY, STATE, ZIP CODE<br>32ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | PR   | ID<br>EFIX<br>FAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                | ΓE                               | (X5)<br>COMPLETION<br>DATE |
| TAG                                                                                                        | advance of the d furnish care, the provided, and the duration of visits.  7. The clinical respective was in advance of the defurnish care, the provided, and the duration of visits.  8. The clinical respective of care) 5/11/16, included a plan of care) 5/11/16, included a plan of certification of 3 orders for home 1 hour a day, 7 depersonal care, base of daily living, reminders and light care plan.  A. The clinical respective was in advance of the discharge OASIS dated 4/2/17. The office of the discharge and the | isciplines that will type of care to be e anticipated frequency / s to be provided.  ecord for patient #9, s reviewed. The clinical evidence that the patient / formed and agreed in isciplines that will type of care to be e anticipated frequency / s to be provided.  ecord for #10, SOC (start was reviewed and of care for the /7/17 to 5/5/17, with health aide services up to lays a week to assist with atthing, dressing, activities neal prep, medication ght housekeeping per  ical record evidenced a S discharge assessment ne clinical record failed t the attending physician d in advance of the luled discharge, the informed in advance of d failed to provide |      | ΓAG               | care to be provided, and frequency/duration of visits. (T begin by 8/25/17) Director of Nursing/designee v audit 100% of admissions to ensure compliance with documenting, at time of admission, that patient/caregiv was notified of disciplines to be provided, type of care to be provided, and frequency/durate of visits. (To begin by 8/25/17) The Director of Nursing will responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recurre | o<br>vill<br>er<br>e<br>on<br>be | DATE                       |
|                                                                                                            | documentation is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | n regards notifying the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |      |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                  |                            |

|                          | OF CORRECTION                                                                                                      | DN IDENTIFICATION NUMBER:  15K064  A. BUILDING  00  B. WING                                                                                                                                    |  | COMPLETED 06/05/2017 |                                                                                                                        |    |                            |
|--------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|------------------------------------------------------------------------------------------------------------------------|----|----------------------------|
| NAME OF 1                | PROVIDER OR SUPPLIER                                                                                               |                                                                                                                                                                                                |  |                      | DDRESS, CITY, STATE, ZIP CODE                                                                                          |    |                            |
| AT HOM                   | E HEALTH SERVIC                                                                                                    | ES LLC                                                                                                                                                                                         |  |                      | 82ND ST STE 216<br>APOLIS, IN 46250                                                                                    |    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                     | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                              |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|                          |                                                                                                                    | th agency and verifying ces being provided.                                                                                                                                                    |  |                      |                                                                                                                        |    |                            |
|                          | C, Interim Direct on 5/31/17 at 2:3 indicated the pat and indicated an agency was in the Health Services           | view with the Employee tor of Clinical Services, 30 p.m., the employee ient notified the agency other home health he home. At Home decided to discharge the ployee indicated a 15 day rovided. |  |                      |                                                                                                                        |    |                            |
|                          | Employee C was any further docu  9. Employee B. Services and Em Assistant Director had no further in               | n relation to the above                                                                                                                                                                        |  |                      |                                                                                                                        |    |                            |
|                          | further informati<br>the exit conferent<br>11. An undated<br>Admission Proce<br>Review the pl<br>treatment, and ca | nd Employee B, had no<br>ton or documentation by<br>the on 6/5/17 at 3:50 p.m.<br>policy titled "Client<br>tess" C- 140, indicated "                                                           |  |                      |                                                                                                                        |    |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 158 of 247

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUILDING 00 COMPLETED  B. WING 06/05/2017                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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| (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                     | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| tient Rights le 12 (b) The percise his or her me health agen The patient helowing: ) Be informed a nished, and of a furnished as fo ) The home heal e patient of any cluding reasonal ased on record a agency failed d / or caregive vance of the dernish care, the ovided, the anteration of visits y changes in the scharged record care (#1 and 1 missions in 20 10. (#3, 4, 5, andings include  The clinical related a writte restriction of 5 | atient has the right to rights as a patient of the cy as follows: has the right to the about the care to be any changes in the care to allows: hath agency shall advise change in the plan of care, ble discharge notice.  review and interview, a to ensure the patient of the review and interview are informed in the plan of care to be accipated frequency and in the patient of the pat | N 05                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 06                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | nurses on need to notify patier caregiver if Medicaid decrease number of hours requested on the PA, obtain MD order for the hours approved by Medicaid a document in patient chart. (To done by 8/25/17)  Director of Nursing/designee was be responsible to ensure orientation of newly hired nursincludes training on need to not patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain Morder for any decrease in the hours approved by Medicaid a document in patient chart. (To begin by 8/25/17)  Director of Nursing/designee was audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | et /<br>es<br>end<br>be<br>vill<br>es<br>otify                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 08/25/2017                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DERECTION  TIDER OR SUPPLIER  SUMMARY ST  (EACH DEFICIENCY REGULATORY OR  THE remarks associated associated associated associated associated as a patient of any electric property of the distribution of the  | IDENTIFICATION NUMBER:  15K064  IDER OR SUPPLIER  EALTH SERVICES LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ternate associated with any procedure ovided in the home "  O IAC 17-12-3(b)(2)(D)(iii) tient Rights le 12 (b) The patient has the right to ercise his or her rights as a patient of the me health agency as follows: The patient has the right to the | DERRECTION DENTIFICATION NUMBER: 15K064  DER OR SUPPLIER EALTH SERVICES LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Ternate associated with any procedure ovided in the home "  O IAC 17-12-3(b)(2)(D)(iii)  Ternate associated with any procedure ovided in the home "  O IAC 17-12-3(b)(2)(D)(iii)  Ternate associated with any procedure ovided in the home "  O IAC 17-12-3(b)(2)(D)(iii)  Ternate associated with any procedure ovided in the home "  O IAC 17-12-3(b)(2)(D)(iii)  Ternate associated with any procedure ovided in the home "  O IAC 17-12-3(b)(2)(D)(iii)  Ternate associated with any procedure ovided in the patient of the me health agency as follows:  The patient has the right to the lowing:  O Be informed about the care to be onlished, and of any changes in the care to furnished as follows:  O The home health agency shall advise expatient of any changes in the plan of care, duding reasonable discharge notice.  Seed on record review and interview, explicitly agency failed to ensure the patient d/ or caregiver were informed in vance of the disciplines that would mush care, the type of care to be ovided, the anticipated frequency / ration of visits to be provided and of yochanges in their care in 2 out of 2 scharged records reviewed of changes care (#1 and 10) and in 6 out of 6 missions in 2016 and 2017 in a sample 10. (#3, 4, 5, 6, 8 and 9)  Indings include:  The clinical record for patient #1 SOC art of care) 3/10/15, was reviewed and cluded a written plan of care for the ritification of 5/9/15 to 7/7/15, with | IDER OR SUPPLIER  EALTH SERVICES LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  OF IAC 17-12-3(b)(2)(D)(iii)  tient Rights le 12 (b) The patient has the right to ercise his or her rights as a patient of the me health agency as follows: The patient has the right to the lowing: Of The home health agency shall advise a patient of any changes in the care to furnished as follows: The home health agency shall advise a patient of any change in the plan of care, eluding reasonable discharge notice. Used on record review and interview, a gaency failed to ensure the patient d / or caregiver were informed in vance of the disciplines that would must care, the type of care to be ovided, the anticipated frequency / ration of visits to be provided and of y changes in their care in 2 out of 2 scharged records reviewed of changes care (#1 and 10) and in 6 out of 6 missions in 2016 and 2017 in a sample 10. (#3, 4, 5, 6, 8 and 9)  Indings include:  The clinical record for patient #1 SOC cart of care) 3/10/15, was reviewed and cluded a written plan of care for the ritification of 5/9/15 to 7/7/15, with | DER CORRECTION  IDENTIFICATION NUMBER: 15K064  IDENTIFICATION NUMBER: 15K0625 RE BIAND ST STE 216 INDIANAPOLIS, IN 46250  IDENTIFICATION NUMBER: 1ANDIANAPOLIS, IN 46250 | DERRECTION   DENTIFICATION NUMBER: 15K064   B. WING   D. COMPT. 06/05.   DER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   6525 E 82ND ST STE 216   INDIANAPOLIS, IN 46250   SUMMARY STATEMENT OF DEFICIENCIES   GEACH DEPRICENCY MUST BE PRECUEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)   PRETIX TAG   DIACA 17-12-3(b)(2)(D)(iii)   tent Rights le 12 (b) The patient has the right to revice his or her rights as a patient of the me health agency as follows: The patient has the right to revise his or her rights as a patient of the me health agency as follows: The patient of any changes in the care to furnished as follows:   The patient has the right to revise his or her rights as a patient of any changes in the plan of care, luding reasonable discharge notice.   Seed on record review and interview, as agency failed to ensure the patient d / or caregiver were informed in vance of the disciplines that would mish care, the type of care to be ovided, the anticipated frequency / ration of visits to be provided and of y changes in their care in 2 out of 2 scharged records reviewed of changes care (#1 and 10) and in 6 out of 6 missions in 2016 and 2017 in a sample 10. (#3, 4, 5, 6, 8 and 9)   Indings include:   The clinical record for patient #1 SOC art of care) 3/10/15, was reviewed and cluded a written plan of care for the trifficiation of 5/9/15 to 7/7/15, with   Medicaid decreased requested hours, Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours. Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requ |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 159 of 247

| STATEMEN  | NT OF DEFICIENCIES                        | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONS |          | ONSTRUCTION                                                             | (X3) DATE SURVEY |            |
|-----------|-------------------------------------------|------------------------------|--------------------|----------|-------------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                             | IDENTIFICATION NUMBER:       | A. BU              | JILDING  | 00                                                                      | COMPL            | ETED       |
|           |                                           | 15K064                       | B. WI              | NG       |                                                                         | 06/05/           | 2017       |
|           |                                           |                              |                    | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                          |                  |            |
| NAME OF I | PROVIDER OR SUPPLIEF                      | 8                            |                    |          | 82ND ST STE 216                                                         |                  |            |
| AT HOM    | E HEALTH SERVIC                           | CES LLC                      |                    |          | APOLIS, IN 46250                                                        |                  |            |
| (X4) ID   | SUMMARY S                                 | TATEMENT OF DEFICIENCIES     |                    | ID       | PROVIDER'S PLAN OF CORRECTION                                           |                  | (X5)       |
| PREFIX    | `                                         | CY MUST BE PRECEDED BY FULL  |                    | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA' | TE               | COMPLETION |
| TAG       | REGULATORY OR                             | LSC IDENTIFYING INFORMATION) |                    | TAG      | DEFICIENCY)                                                             |                  | DATE       |
|           | I -                                       | days a week to assist        |                    |          | there is documentation                                                  | - 4              |            |
|           | with grooming, l                          | hygiene, transfers,          |                    |          | patient/caregiver was notified the decrease and MD order was            |                  |            |
|           | medication remi                           | nders, meal preparation /    |                    |          | obtained for authorized                                                 | 43               |            |
|           | setup, and light l                        | nousekeeping. The            |                    |          | frequency. Once 100%                                                    |                  |            |
|           | patient had a dia                         | gnosis of Multiple           |                    |          | compliance is achieved, Direct                                          | tor              |            |
|           | Sclerosis.                                |                              |                    |          | of Nursing/designee will audit,                                         |                  |            |
|           |                                           | -                            |                    |          | monthly, 25% of Medicaid                                                |                  |            |
|           | Λ Ρουίουν                                 | of the payroll time          |                    |          | authorizations received that                                            | iith             |            |
|           |                                           | ne health aides were         |                    |          | month to ensure compliance w notifying patient/caregiver of a           |                  |            |
|           | · · · · · · · · · · · · · · · · · · ·     |                              |                    |          | decrease in hours approved a                                            | -                |            |
|           | providing services up from 5 to 7 hours a |                              |                    |          | MD order obtained for authoriz                                          |                  |            |
|           | day                                       |                              |                    |          | frequency. (To begin by 8/25/1                                          | 17)              |            |
|           |                                           |                              |                    |          | Director of Nursing will in-serv                                        |                  |            |
|           | B. Review                                 | of the FSSA (Family          |                    |          | nursing staff on documenting,                                           | at               |            |
|           | Social Service A                          | dministration) Medicaid      |                    |          | time of admission, that                                                 | - £              |            |
|           | paperwork dated                           | 16/2/15, indicated the       |                    |          | patient/caregiver was notified disciplines to be provided, type         |                  |            |
|           | patient's original                        | prior authorization          |                    |          | care to be provided, and                                                | 5 01             |            |
|           |                                           | lified and that the          |                    |          | frequency/duration of visits. (T                                        | o                |            |
|           | -                                         | were excessie based on       |                    |          | be completed by 8/25/17)                                                |                  |            |
|           | _                                         | imentation submitted.        |                    |          | Director of Nursing will be                                             |                  |            |
|           | the medical doct                          | inicitation submitted.       |                    |          | responsible to ensure orientati                                         |                  |            |
|           | C D :                                     | CA FORAN II II               |                    |          | of newly hired nurses includes                                          |                  |            |
|           |                                           | of the FSSA Medicaid         |                    |          | training on documenting, at tin of admission, that                      | ie               |            |
|           |                                           | 1 6/17/15, indicated the     |                    |          | patient/caregiver was notified                                          | of               |            |
|           |                                           | se the home health aide      |                    |          | disciplines to be provided, type                                        |                  |            |
|           | services were de                          | nied as medically not        |                    |          | care to be provided, and                                                |                  |            |
|           | necessary.                                |                              |                    |          | frequency/duration of visits. (T                                        | o                |            |
|           |                                           |                              |                    |          | begin by 8/25/17)                                                       | .,,              |            |
|           | D. Review                                 | of the communications        |                    |          | Director of Nursing/designee v                                          | VIII             |            |
|           | notes dated 6/15                          | /15, 6/18/15, 7/5/15 and     |                    |          | audit 100% of admissions to ensure compliance with                      |                  |            |
|           |                                           | n 6/30/15, the agency        |                    |          | documenting, at time of                                                 |                  |            |
|           | _                                         | te that the patient and / or |                    |          | admission, that patient/caregiv                                         | /er              |            |
|           |                                           | formed of Medicaid's         |                    |          | was notified of disciplines to be                                       |                  |            |
|           | _                                         | ease the home health aide    |                    |          | provided, type of care to be                                            |                  |            |
|           |                                           |                              |                    |          | provided, and frequency/durat                                           |                  |            |
|           |                                           | making a change in the       |                    |          | of visits. (To begin by 8/25/17)                                        |                  |            |
|           | agency's ability                          | to service the patient.      |                    |          | Director of Nursing will in-serv                                        | ic <del>e</del>  |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                      | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |       |          | SURVEY                                                             |                   |            |
|------------------------------------------------------|--------------------------------------|---------------------------------------------|-------|----------|--------------------------------------------------------------------|-------------------|------------|
| AND PLAN                                             | OF CORRECTION                        | IDENTIFICATION NUMBER:                      | A. BU | JILDING  | 00                                                                 | COMPL             | ETED       |
|                                                      |                                      | 15K064                                      | B. W  | ING      |                                                                    | 06/05/            | 2017       |
|                                                      |                                      |                                             |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                     |                   |            |
| NAME OF I                                            | PROVIDER OR SUPPLIER                 | 2                                           |       |          | 82ND ST STE 216                                                    |                   |            |
| AT HOM                                               | E HEALTH SERVIC                      | CESTIC                                      |       |          | IAPOLIS, IN 46250                                                  |                   |            |
|                                                      |                                      |                                             |       |          | GEIG, IIV 16266                                                    |                   |            |
| (X4) ID                                              |                                      | TATEMENT OF DEFICIENCIES                    |       | ID       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |                   | (X5)       |
| PREFIX                                               |                                      | CY MUST BE PRECEDED BY FULL                 |       | PREFIX   | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                    | TE                | COMPLETION |
| TAG                                                  | REGULATORY OR                        | LSC IDENTIFYING INFORMATION)                | +     | TAG      | · ·                                                                |                   | DATE       |
|                                                      |                                      |                                             |       |          | nursing staff on requirement to notify MD of a patient's discha    |                   |            |
|                                                      |                                      |                                             |       |          | notify patient/caregiver of                                        | ıy <del>c</del> , |            |
|                                                      | 2. The clinical record number 3, SOC |                                             |       |          | discharge at least fifteen (15)                                    |                   |            |
|                                                      | (start of care) 11                   | /28/16, was reviewed.                       |       |          | days before discharge and                                          |                   |            |
|                                                      | The clinical reco                    | ord failed to evidence that                 |       |          | notifying any other agency                                         |                   |            |
|                                                      |                                      | giver was informed and                      |       |          | involved in patient's care of                                      |                   |            |
|                                                      | _                                    | ce of the disciplines that                  |       |          | upcoming discharge of patient                                      |                   |            |
|                                                      | -                                    | , the type of care to be                    |       |          | from agency. Nurses to docum                                       |                   |            |
|                                                      |                                      |                                             |       |          | these conversations in patient chart. (To be completed by          | S                 |            |
|                                                      |                                      | e anticipated frequency /                   |       |          | 8/25/17)                                                           |                   |            |
|                                                      | duration of visits                   | s to be provided.                           |       |          | Director of Nursing will be                                        |                   |            |
|                                                      |                                      |                                             |       |          | responsible to ensure orientati                                    | on                |            |
|                                                      | 3. The clinical r                    | ecord number 4, SOC                         |       |          | of newly hired nurses includes                                     |                   |            |
|                                                      | 4/24/16, was rev                     | iewed. The clinical                         |       |          | training on requirement to noti                                    | -                 |            |
|                                                      | record failed to                     | evidence that the patient /                 |       |          | MD of a patient's discharge, no                                    |                   |            |
|                                                      |                                      | formed and agreed in                        |       |          | patient/caregiver of discharge                                     | at                |            |
|                                                      | 1                                    | isciplines that will                        |       |          | least fifteen (15) days before                                     | hor               |            |
|                                                      |                                      | type of care to be                          |       |          | discharge and notifying any ot agency involved in patient's ca     |                   |            |
|                                                      |                                      |                                             |       |          | of upcoming discharge of patie                                     |                   |            |
|                                                      |                                      | e anticipated frequency /                   |       |          | from agency. Nurses to docum                                       |                   |            |
|                                                      | duration of visits                   | s to be provided.                           |       |          | these conversations in patient'                                    |                   |            |
|                                                      |                                      |                                             |       |          | chart. (To begin by 8/25/17)                                       |                   |            |
|                                                      | 4. The clinical r                    | ecord for patient #5,                       |       |          | Director of Nursing/designee v                                     | vill              |            |
|                                                      | SOC 11/21/16, v                      | vas reviewed. The                           |       |          | audit 100% of discharges to                                        |                   |            |
|                                                      | clinical record fa                   | ailed to evidence that the                  |       |          | ensure compliance with notifyi MD of upcoming discharge,           | ng                |            |
|                                                      | patient / caregive                   | er was informed and                         |       |          | notifying patient of discharge a                                   | at                |            |
|                                                      | 1                                    | ce of the disciplines that                  |       |          | least fifteen (15) days before                                     |                   |            |
|                                                      | _                                    | , the type of care to be                    |       |          | discharge and notifying other                                      |                   |            |
|                                                      |                                      | e anticipated frequency /                   |       |          | agencies involved in patient's                                     |                   |            |
|                                                      |                                      | 1 1                                         |       |          | care of patient's upcoming                                         |                   |            |
|                                                      | duration of visits                   | s to be provided.                           |       |          | discharge from agency. (To be                                      | egin              |            |
|                                                      |                                      |                                             |       |          | by 8/25/17)                                                        | ha                |            |
|                                                      |                                      | ecord for patient #6,                       |       |          | The Director of Nursing will                                       | be                |            |
|                                                      | ·                                    | as reviewed. The clinical                   |       |          | responsible for monitoring                                         |                   |            |
|                                                      | record failed to                     | evidence that the patient /                 |       |          | these corrective actions to                                        |                   |            |
|                                                      | caregiver was in                     | formed and agreed in                        |       |          | ensure that this deficiency is                                     |                   |            |
|                                                      | 1                                    | isciplines that will                        |       |          | corrected and will not recur.                                      | •                 |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 161 of 247

|               | T OF DEFICIENCIES                      | X1) PROVIDER/SUPPLIER/CLIA                               | l í           |                | NSTRUCTION                                                                             | (X3) DATE S      |                    |
|---------------|----------------------------------------|----------------------------------------------------------|---------------|----------------|----------------------------------------------------------------------------------------|------------------|--------------------|
| AND PLAN      | OF CORRECTION                          | IDENTIFICATION NUMBER: 15K064                            | A. B.<br>B. W | JILDING<br>ING | 00                                                                                     | COMPL:<br>06/05/ |                    |
|               |                                        | 101/004                                                  |               |                | DDDECC CITY CTATE ZID CODE                                                             | 00/00/           | 2017               |
| NAME OF P     | ROVIDER OR SUPPLIER                    | ł                                                        |               |                | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                      |                  |                    |
| AT HOME       | E HEALTH SERVIC                        | CES LLC                                                  |               |                | APOLIS, IN 46250                                                                       |                  |                    |
| (X4) ID       |                                        | TATEMENT OF DEFICIENCIES                                 |               | ID             | PROVIDER'S PLAN OF CORRECTION                                                          |                  | (X5)               |
| PREFIX<br>TAG | *                                      | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |               | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE               | COMPLETION<br>DATE |
| TAG           |                                        | type of care to be                                       |               | TAG            | Birchivery                                                                             |                  | DATE               |
|               |                                        | e anticipated frequency /                                |               |                |                                                                                        |                  |                    |
|               | duration of visits                     |                                                          |               |                |                                                                                        |                  |                    |
|               | daration of visits                     | to be provided.                                          |               |                |                                                                                        |                  |                    |
|               | 6. The clinical r                      | ecord for patient #8,                                    |               |                |                                                                                        |                  |                    |
|               | SOC 8/3/16, was reviewed. The clinical |                                                          |               |                |                                                                                        |                  |                    |
|               | · ·                                    | evidence that the patient /                              |               |                |                                                                                        |                  |                    |
|               | caregiver was in                       | formed and agreed in                                     |               |                |                                                                                        |                  |                    |
|               | advance of the disciplines that will   |                                                          |               |                |                                                                                        |                  |                    |
|               |                                        | type of care to be                                       |               |                |                                                                                        |                  |                    |
|               | •                                      | e anticipated frequency /                                |               |                |                                                                                        |                  |                    |
|               | duration of visits                     | s to be provided.                                        |               |                |                                                                                        |                  |                    |
|               | 7 The clinical r                       | agard for nations #0                                     |               |                |                                                                                        |                  |                    |
|               |                                        | ecord for patient #9,<br>s reviewed. The clinical        |               |                |                                                                                        |                  |                    |
|               | · ·                                    | evidence that the patient /                              |               |                |                                                                                        |                  |                    |
|               |                                        | formed and agreed in                                     |               |                |                                                                                        |                  |                    |
|               | _                                      | isciplines that will                                     |               |                |                                                                                        |                  |                    |
|               |                                        | type of care to be                                       |               |                |                                                                                        |                  |                    |
|               | · ·                                    | e anticipated frequency /                                |               |                |                                                                                        |                  |                    |
|               | duration of visits                     |                                                          |               |                |                                                                                        |                  |                    |
|               |                                        |                                                          |               |                |                                                                                        |                  |                    |
|               |                                        | ecord for #10, SOC (start                                |               |                |                                                                                        |                  |                    |
|               | ,                                      | was reviewed and                                         |               |                |                                                                                        |                  |                    |
|               | included a plan of                     |                                                          |               |                |                                                                                        |                  |                    |
|               |                                        | /7/17 to 5/5/17, with                                    |               |                |                                                                                        |                  |                    |
|               |                                        | health aide services up to                               |               |                |                                                                                        |                  |                    |
|               | •                                      | lays a week to assist with                               |               |                |                                                                                        |                  |                    |
|               | •                                      | athing, dressing, activities                             |               |                |                                                                                        |                  |                    |
|               |                                        | neal prep, medication                                    |               |                |                                                                                        |                  |                    |
|               | care plan.                             | ght housekeeping per                                     |               |                |                                                                                        |                  |                    |
|               | care pian.                             |                                                          |               |                |                                                                                        |                  |                    |
|               | A. The clin                            | ical record evidenced a                                  |               |                |                                                                                        |                  |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 162 of 247

|                          | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                | A. BUILDING <u>00</u> B. WING |                                                                                                                | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
| AT HOM                   | PROVIDER OR SUPPLIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                         | 6525 E                        | ADDRESS, CITY, STATE, ZIP CODE<br>8 82ND ST STE 216<br>NAPOLIS, IN 46250                                       | •                                     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)                                                                                                                  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | BE (                                  | (X5)<br>COMPLETION<br>DATE |
|                          | dated 4/2/17. The dated 4/2/17. The evidenced that had been notified patient's unsched patient had been the discharge and documentation is other home heal the type of servition. B. An interfact C, Interim Direction 5/31/17 at 2:20 indicated the pata and indicated and agency was in the Health Services patient. The employee C was any further documentation in findings on 6/2/10 indicated the pata and indicated and agency was in the Health Services patient. The employee C was any further documentation in findings on 6/2/10 indicated the pata and indicated and agency was in the Health Services patient. The employee C was any further documentation in findings on 6/2/10 indicated the pata and indicated andicated and indicated and indicated and indicated and indicated a | /17 at 2:30 p.m., s not unable to provide imentation upon request.  , the Director of Clinical imployee C, the Interim or of Clinical Services, information or in relation to the above 17 at 4:00 p.m. |                               |                                                                                                                |                                       |                            |
|                          | 10. Employee <i>A</i> Administrator an                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A, the Alternate<br>nd Employee B, had no                                                                                                                                                               |                               |                                                                                                                |                                       |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 163 of 247

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 06/05/2017                                                                                                                                                                                                                                                                                                                     |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                               | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                        | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X5) COMPLETION DATE                                |
|                                                                                                            |                                                                                                                                                                                                                                                                                                                                                       | on or documentation by ce on 6/5/17 at 3:50 p.m.                                                                                                                                                                                                                                                                                                                                                              |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |
|                                                                                                            | Admission Proce<br>Review the pl<br>treatment, and ca<br>caregiver of any                                                                                                                                                                                                                                                                             | reasonable risk and / or<br>ted with any procedure                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |
| N 0522<br>Bldg. 00                                                                                         | a written medical and periodically redentist, chiropract podiatrist, as follows Based on record the agency failed the plan of care and duration of parent and duration of parent and providing physician's order reviewed in a same Findings includes 1. The clinical respectively 128/16, in the certification 5/26/17, with order every 14 days for | Medical care shall follow blan of care established eviewed by the physician, or, optometrist or ws: review and interview, do to ensure staff followed in relation to frequency batient visits, personal ling services without a rein 3 of 7 active records imple of 10. (#3, 4 and 6)  ecord for patient #3, included a plan of care for period of 03/28/17 to ders for skilled nursing in medication set up. | N 0522              | Director of Nursing will in-serv<br>nurses on requirement to follo<br>Plan of Care which includes<br>frequency and duration for<br>disciplines ordered by MD and<br>was tasks nurse is to provide.<br>visit is not made, nurse will<br>document reason, complete a<br>missed visit report and notify I<br>of missed visit. If patient requi<br>a task that is not listed on the<br>Plan of care, nurse will contact<br>MD and obtain an order for the<br>needed task. If LPN notes the<br>is something needed that is no<br>on the Plan of Care, LPN will<br>contact he RN case manager<br>Director of Nursing to discuss<br>patient's need before MD is | d If a MD dres et e e e e e e e e e e e e e e e e e |
|                                                                                                            |                                                                                                                                                                                                                                                                                                                                                       | cilled nursing visit notes clinical record, the                                                                                                                                                                                                                                                                                                                                                               |                     | contacted. (To be completed by 8/25/17)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ру                                                  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 164 of 247

| STATEMEN  | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) !                                                        |                              | (X2) M   | X2) MULTIPLE CONSTRUCTION |                                                                                                    |        | (X3) DATE SURVEY |  |
|-----------|------------------------------------------------------------------------------------------------------------------|------------------------------|----------|---------------------------|----------------------------------------------------------------------------------------------------|--------|------------------|--|
| AND PLAN  | OF CORRECTION                                                                                                    | IDENTIFICATION NUMBER:       | A. BU    | JILDING                   | 00                                                                                                 | COMPL  | ETED             |  |
|           |                                                                                                                  | 15K064                       | B. Wl    | ING                       |                                                                                                    | 06/05/ | 2017             |  |
|           |                                                                                                                  |                              | <u> </u> | STREET A                  | ADDRESS, CITY, STATE, ZIP CODE                                                                     |        |                  |  |
| NAME OF I | PROVIDER OR SUPPLIEF                                                                                             | <b>{</b>                     |          |                           | 82ND ST STE 216                                                                                    |        |                  |  |
|           | E HEALTH SERVIC                                                                                                  | CES LLC                      |          | INDIAN                    | APOLIS, IN 46250                                                                                   |        |                  |  |
| (X4) ID   |                                                                                                                  | TATEMENT OF DEFICIENCIES     |          | ID                        | PROVIDER'S PLAN OF CORRECTION                                                                      |        | (X5)             |  |
| PREFIX    | `                                                                                                                | ICY MUST BE PRECEDED BY FULL |          | PREFIX                    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | ΓE     | COMPLETION       |  |
| TAG       |                                                                                                                  | LSC IDENTIFYING INFORMATION) |          | TAG                       | · ·                                                                                                |        | DATE             |  |
|           | •                                                                                                                | ontained a skilled nursing   |          |                           | Director of Nursing will be responsible to ensure orientati                                        | on     |                  |  |
|           | visit note on 03/29/17, 4/21/17, 5/5/17,                                                                         |                              |          |                           | of newly hired nurses includes                                                                     |        |                  |  |
|           | •                                                                                                                | 3/17. The clinical record    |          |                           | training on requirement to follo                                                                   |        |                  |  |
|           | failed to evidence                                                                                               | ee a skilled nursing visit   |          |                           | Plan of Care which includes                                                                        |        |                  |  |
|           | between 04/09/1                                                                                                  | 7 to 4/15/17.                |          |                           | frequency and duration for                                                                         |        |                  |  |
|           |                                                                                                                  |                              |          |                           | disciplines ordered by MD and                                                                      |        |                  |  |
|           | 2. The clinical r                                                                                                | ecord for patient #4,        |          |                           | was tasks nurse is to provide. visit is not made, nurse will                                       | па     |                  |  |
|           | SOC 4/24/17, in                                                                                                  | cluded a plan of care for    |          |                           | document reason, complete a                                                                        |        |                  |  |
|           | -                                                                                                                | period of 4/24/17 to         |          |                           | missed visit report and notify N                                                                   | /ID    |                  |  |
|           |                                                                                                                  | ders for a licensed          |          |                           | of missed visit. If patient require                                                                | es     |                  |  |
|           | practical nurse (LPN) up to 3 hours per                                                                          |                              |          |                           | a task that is not listed on the                                                                   |        |                  |  |
|           | day, 5 days a week to assist with personal                                                                       |                              |          |                           | Plan of care, nurse will contact MD and obtain an order for the                                    |        |                  |  |
|           | care, transfers, medication reminders,                                                                           |                              |          |                           | needed task. If LPN notes the                                                                      |        |                  |  |
|           |                                                                                                                  | 1 / setup, and light         |          |                           | is something needed that is no                                                                     |        |                  |  |
|           |                                                                                                                  | 1/ Setup, and right          |          |                           | on the Plan of Care, LPN will                                                                      |        |                  |  |
|           | housekeeping.                                                                                                    |                              |          |                           | contact he RN case manager                                                                         | or     |                  |  |
|           |                                                                                                                  |                              |          |                           | Director of Nursing to discuss                                                                     |        |                  |  |
|           | _                                                                                                                | home visit on 6/1/17 at      |          |                           | patient's need before MD is                                                                        | 7)     |                  |  |
|           | _                                                                                                                | PN was observed to           |          |                           | contacted. (To begin by 8/25/1 Director of Nursing/designee w                                      |        |                  |  |
|           | administer liquio                                                                                                | d dilantin (anti-seizure     |          |                           | audit 100% of nursing                                                                              | ,      |                  |  |
|           | medication), tyle                                                                                                | enol and ibuprofen (used     |          |                           | documentation weekly, until                                                                        |        |                  |  |
|           | for mild pain and                                                                                                | d / or fever) and            |          |                           | 100% compliance is achieved,                                                                       |        |                  |  |
|           | approximately 1                                                                                                  | 00 ml (milliliters) of       |          |                           | monitor compliance with follow                                                                     | ring   |                  |  |
|           | water flush throu                                                                                                | igh the patient's gastric    |          |                           | frequency and duration for disciplines ordered by MD as v                                          | المر   |                  |  |
|           | tube (g-tube) be                                                                                                 | fore, during, and after      |          |                           | MD ordered plan of care and t                                                                      |        |                  |  |
|           |                                                                                                                  | inistration. In the          |          |                           | care provided follows the MD                                                                       |        |                  |  |
|           |                                                                                                                  | of paper that was secured    |          |                           | ordered Plan of Care. Once 10                                                                      |        |                  |  |
|           |                                                                                                                  | contained a list of          |          |                           | compliance is achieved, Direct                                                                     | or     |                  |  |
|           |                                                                                                                  | water flushes with times     |          |                           | of Nursing/designee will audit                                                                     |        |                  |  |
|           |                                                                                                                  | The LPN indicated the        |          |                           | 25% of nursing documentation monthly to monitor for continue                                       |        |                  |  |
|           |                                                                                                                  |                              |          |                           | compliance. (To begin 8/25/17                                                                      |        |                  |  |
|           | spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff |                              |          |                           | Director of Nursing/designee v                                                                     |        |                  |  |
|           |                                                                                                                  |                              |          |                           | instruct clinical staff, if patient                                                                | s      |                  |  |
|           |                                                                                                                  |                              |          |                           | receiving services thru more th                                                                    | nan    |                  |  |
|           |                                                                                                                  | dminister. The LPN           |          |                           | one payer, to indicate on visit                                                                    | _      |                  |  |
|           | indicated she wo                                                                                                 | ould provide g-tube site     |          |                           | note which payer this visit is fo                                                                  | r.     |                  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 165 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                           | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |               |                              | SURVEY                                                                  |              |            |
|------------------------------------------------------|-------------------------------------------|---------------------------------------------|---------------|------------------------------|-------------------------------------------------------------------------|--------------|------------|
| AND PLAN                                             | OF CORRECTION                             | IDENTIFICATION NUMBER:                      | A. BU         | ILDING                       | 00                                                                      | COMPL        | ETED       |
|                                                      |                                           | 15K064                                      | B. WI         | NG                           |                                                                         | 06/05/       | 2017       |
|                                                      |                                           |                                             | <del></del> _ | STREET A                     | ADDRESS, CITY, STATE, ZIP CODE                                          |              |            |
| NAME OF F                                            | ROVIDER OR SUPPLIER                       | 8                                           |               |                              |                                                                         |              |            |
|                                                      |                                           | 250110                                      |               |                              | 82ND ST STE 216<br>APOLIS, IN 46250                                     |              |            |
| AT HOWI                                              | E HEALTH SERVIC                           | ES LLC                                      |               | INDIAN                       | APOLIS, IN 46250                                                        |              |            |
| (X4) ID                                              | SUMMARY S                                 | TATEMENT OF DEFICIENCIES                    |               | ID                           | PROVIDER'S PLAN OF CORRECTION                                           |              | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                            | CY MUST BE PRECEDED BY FULL                 | ]             | PREFIX                       | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | ΓE           | COMPLETION |
| TAG                                                  | REGULATORY OR                             | LSC IDENTIFYING INFORMATION)                |               | TAG                          | DEFICIENCY)                                                             |              | DATE       |
|                                                      | care after the pat                        | tient received a bath.                      |               |                              | (To be completed by 8/25/17)                                            |              |            |
|                                                      | •                                         |                                             |               |                              | Director of Nursing will be                                             |              |            |
|                                                      | D Davious                                 | of the skilled nursing visit                |               |                              | responsible to ensure orientation                                       | on           |            |
|                                                      |                                           | _                                           |               |                              | of newly hired clinical staff                                           |              |            |
|                                                      | notes indicated t                         | ne following:                               |               |                              | includes training on, if patient i                                      |              |            |
|                                                      |                                           |                                             |               |                              | receiving services thru more th                                         | nan          |            |
|                                                      | 1. On 4                                   | /27, 4/28, 5/2, 5/3, 5/4,                   |               |                              | one payer, to indicate on visit                                         | .r           |            |
|                                                      | 5/5, 5/8, 5/9, 5/1                        | 0, 5/11, 5/15, 5/16, 5/17,                  |               |                              | note which payer this visit is fo (To begin by 8/25/17)                 | и.           |            |
|                                                      | 5/18 5/22 5/23                            | 5/24, 5/25, 5/30, 5/31,                     |               |                              | Director of Nursing/designee w                                          | <i>i</i> ill |            |
|                                                      |                                           |                                             |               |                              | audit 100% of visit notes, week                                         |              |            |
|                                                      | 6/1 and 6/2/17, the visit notes indicated |                                             |               |                              | for patients receiving visits thru                                      | -            |            |
| the skilled nurse administered tube                  |                                           |                                             |               |                              | multiple payers to monitor                                              | -            |            |
| feedings.                                            |                                           |                                             |               | compliance with marking paye | r                                                                       |              |            |
|                                                      |                                           |                                             |               |                              | on documentation. Once 100%                                             | ,<br>D       |            |
|                                                      | 2. On 5                                   | 5/8, 5/9, 5/10, 5/11, 5/15,                 |               |                              | compliance is achieved, Direct                                          | or           |            |
|                                                      | 5/16, 5/24, 5/25,                         | 5/30, 5/31, 6/1 and                         |               |                              | of Nursing/designee will audit                                          |              |            |
|                                                      |                                           | notes indicated the                         |               |                              | 25% of visit notes, monthly, to                                         |              |            |
|                                                      | -                                         | ninistered water flushes.                   |               |                              | monitor for compliance. (To be                                          | gin          |            |
|                                                      | skilled liurse adr                        | innistered water flushes.                   |               |                              | by 8/25/17) The Director of Nursing will be                             |              |            |
|                                                      | 2 0 5                                     | 105 5100 5101 611 1                         |               |                              | responsible for monitoring thes                                         |              |            |
|                                                      |                                           | /25, 5/30, 5/31, 6/1 and                    |               |                              | corrective actions to ensure that                                       |              |            |
|                                                      | 6/2/17, the visit                         | notes indicated the                         |               |                              | this deficiency is corrected and                                        |              |            |
|                                                      | skilled nurse pro                         | vided g-tube site care.                     |               |                              | will not recur.                                                         |              |            |
|                                                      | _                                         |                                             |               |                              |                                                                         |              |            |
|                                                      | 4 On 5                                    | /4, 5/17, 5/25, 5/31, 6/1,                  |               |                              |                                                                         |              |            |
|                                                      |                                           | visit notes indicated the                   |               |                              |                                                                         |              |            |
|                                                      | · ·                                       | s in the home for 4 hours                   |               |                              |                                                                         |              |            |
|                                                      |                                           |                                             |               |                              |                                                                         |              |            |
|                                                      | and for 10 hours                          | on 5/23/17.                                 |               |                              |                                                                         |              |            |
|                                                      |                                           |                                             |               |                              |                                                                         |              |            |
|                                                      | 5. Thre                                   | e (3) skilled nursing visits                |               |                              |                                                                         |              |            |
|                                                      | were made week                            | 1 and 4 of the                              |               |                              |                                                                         |              |            |
|                                                      | certification peri                        | od and 4 skilled nursing                    |               |                              |                                                                         |              |            |
|                                                      | _                                         | e week 2, 3, 5, and 6 of                    |               |                              |                                                                         |              |            |
|                                                      |                                           |                                             |               |                              |                                                                         |              |            |
|                                                      | the certification                         | perioa.                                     |               |                              |                                                                         |              |            |
|                                                      |                                           |                                             |               |                              |                                                                         |              |            |
|                                                      | 6. On 4                                   | /25, 4/27, 4/28, 5/2, 5/3,                  |               |                              |                                                                         |              |            |
|                                                      | 5/4, 5/5, 5/8, 5/9                        | , 5/10, 5/11, 5/15, 5/16,                   |               |                              |                                                                         |              |            |
|                                                      |                                           |                                             | 1             |                              |                                                                         |              |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                              | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                  |                      |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                         |                                                                                                                                                                                                           | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                                 | •                    |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                               | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                                                                            |                                                                                                              | 5/23 and 5/24/17, failed ersonal care had been                                                                                                                                                            |                     |                                                                                                                        |                      |
|                                                                                                            | plan of care in red<br>duration of visits                                                                    | es failed to follow the egards to frequency and s, providing personal providing services ian's order.                                                                                                     |                     |                                                                                                                        |                      |
|                                                                                                            | SOC 1/30/17, in the certification 5/29/17, with order visit per day, up times per week to                    | ecord for patient #6,<br>ncluded a plan of care for<br>period of 3/31/17 to<br>ders for skilled nursing 1<br>to 2 hours per visit, 3<br>o remove and apply a<br>one day per week.                         |                     |                                                                                                                        |                      |
|                                                                                                            | notes on 3/31, 4/4/14, 4/12, 4/19, 5/1, 5/3, 5/5, 5/8 5/19, 5/22, 5/24, visit notes failed patient's uroston | of the skilled nursing visit 73, 4/5, 4/7, 4/10, 4/12, 4/21, 4/24, 4/26, 4/28, 5/10, 5/12, 5/15, 5/17, 5/26, and 5/29/17, the to evidence that the ny wafer had been The skilled nurse failed in of care. |                     |                                                                                                                        |                      |
|                                                                                                            | Services and Em<br>Assistant Direct<br>had no further in                                                     | n relation to the above                                                                                                                                                                                   |                     |                                                                                                                        |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 167 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE C A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                      | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                         |                      |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                          | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                      |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | SUMMARY S'<br>(EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                              | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| N 0524                                                                                                     | on 6/5/17 at 3:50 of hours may be being included in Authorization hothere is no deline                                                                                                                                                                                                                                                                                                                                                    | nd Employee B, indicated O p.m., that the overage due to waiver hours n the Medicaid Prior ours. Both indicated eation on notes.                                                                                                                                                                                                                         |                     |                                                                                                               |                      |
| N 0524<br>Bidg. 00                                                                                         | plan of care shall:  (A) Be developed home health agen (B) Include all ser skilled service is b (B) Cover all pertic (C) Include the fo (i) Mental statu (ii) Types of ser required.  (iii) Frequency a (iv) Prognosis.  (v) Rehabilitatio (vi) Functional lii (vii) Activities per (viii) Nutritional re (ix) Medications (x) Any safety against injury.  (xi) Instructions referral.  (xii) Therapy mod treatment.  (xiii) Any other ap | (1) As follows, the medical d in consultation with the next staff.  rvices to be provided if a peing provided. inent diagnoses. In policy staff.  rvices and equipment and duration of visits.  on potential. In mitations. In rmitted. In equipments. In and treatments. In measures to protect a for timely discharge or dalities specifying length of | N 0524              | Director of Nursing/designee v                                                                                |                      |
|                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                           | d to ensure the plan of                                                                                                                                                                                                                                                                                                                                  | N 0324              | instruct nurses when patient h<br>order for home health aide to<br>indicate who is responsible to             |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 168 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION |          |                                                                                       | (X3) DATE SURVEY  |            |
|-----------|------------------------------------------------------|------------------------------|----------------------------|----------|---------------------------------------------------------------------------------------|-------------------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU                      | JILDING  | 00                                                                                    | COMPL             | ETED       |
|           |                                                      | 15K064                       | B. WI                      | NG       |                                                                                       | 06/05/            | 2017       |
| NAME OF I | DOWNER OF CLIDALIE                                   |                              |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                        |                   |            |
| NAME OF F | PROVIDER OR SUPPLIEF                                 | X.                           |                            | 6525 E   | 82ND ST STE 216                                                                       |                   |            |
|           | E HEALTH SERVIC                                      | ES LLC                       | _                          | INDIAN   | APOLIS, IN 46250                                                                      |                   | _          |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES     |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                                         |                   | (X5)       |
| PREFIX    | `                                                    | CY MUST BE PRECEDED BY FULL  |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                | COMPLETION |
| TAG       |                                                      | LSC IDENTIFYING INFORMATION) | +                          | TAG      | determine how many hours                                                              |                   | DATE       |
|           |                                                      | duration of home health      |                            |          | patient needs when order says                                                         | s                 |            |
|           | -                                                    | fic and pertinent to the     |                            |          | "up to" number of hours. Nurse                                                        |                   |            |
|           | patient's needs in 6 out of 7 active                 |                              |                            |          | should indicate if patient is                                                         |                   |            |
|           |                                                      | d (#2, 3, 4, 5, 7 and 8) of  |                            |          | cognitive to make own person                                                          | al                |            |
|           | •                                                    | me health aides in a         |                            |          | care decisions. If not then                                                           |                   |            |
|           | sample of 10; far                                    |                              |                            |          | indicate who determines time caregiver, RN, etc. (To be                               | _                 |            |
|           | parameters for sl                                    | killed nursing to obtain     |                            |          | completed by 8/25/17)                                                                 |                   |            |
|           | oxygen saturatio                                     | ns in 7 out of 8 active      |                            |          | Director of Nursing will be                                                           |                   |            |
|           | records reviewed                                     | d (#2, 3, 4, 5, 6, 7 and 8)  |                            |          | responsible to ensure orientat                                                        |                   |            |
|           | in a sample of 10                                    | ); failed to update a        |                            |          | of newly hired nurses includes                                                        |                   |            |
|           | patient's persona                                    | l location of services to    |                            |          | instructing nurses when patier has order for home health aide                         |                   |            |
|           | be provided on the plan of care in 1 of 5            |                              |                            |          | indicate who is responsible to                                                        | <del>-</del> 10   |            |
|           | •                                                    | lucted (#2); failed to       |                            |          | determine how many hours                                                              |                   |            |
|           |                                                      | tion profile in 2 out of 8   |                            |          | patient needs when order says                                                         |                   |            |
|           | _                                                    | viewed (#3 and 6), failed    |                            |          | "up to" number of hours. Nurse                                                        | es                |            |
|           |                                                      | e site care, the amount      |                            |          | should indicate if patient is                                                         | al.               |            |
|           | _                                                    | f water flushes, the name,   |                            |          | cognitive to make own person care decisions. If not then                              | aı                |            |
|           |                                                      | quency of tube feedings,     |                            |          | indicate who determines time                                                          | _                 |            |
|           |                                                      |                              |                            |          | caregiver, RN, etc. (To begin l                                                       | ру                |            |
|           |                                                      | on the use of the Trilogy    |                            |          | 8/25/17)                                                                              |                   |            |
|           |                                                      | machine for oxygen           |                            |          | Director of Nursing/designee v                                                        |                   |            |
|           |                                                      | record reviewed of a         |                            |          | audit, weekly, 100% of Plans of Care to monitor for compliance                        |                   |            |
|           | -                                                    | be and a vent / bypap        |                            |          | with indicating who is respons                                                        |                   |            |
|           | ` ' '                                                | nd failed to include other   | 1                          |          | to determine how many hours                                                           |                   |            |
|           | _                                                    | es assisting with the        | 1                          |          | patient needs when order says                                                         | S                 |            |
|           | •                                                    | 2 out of 4 active records    | 1                          |          | "up to" number of hours. Nurse                                                        | es                |            |
|           | of patients with                                     | more than one service in     | 1                          |          | should indicate if patient is                                                         | ol.               |            |
|           | a sample of 10.                                      | (# 6 and 7)                  | 1                          |          | cognitive to make own person care decisions. If not then                              | aı                |            |
|           |                                                      |                              | 1                          |          | indicate who determines time                                                          | _                 |            |
|           | Findings include                                     | ):                           |                            |          | caregiver, RN, etc. Once 100%                                                         |                   |            |
|           |                                                      |                              |                            |          | compliance is achieved, Direc                                                         | tor               |            |
|           | 1. The clinical r                                    | ecord for patient #2,        |                            |          | of Nursing/designee will audit                                                        | 4-                |            |
|           |                                                      | re) 3/6/12, included a       |                            |          | 25% of Plans of Care monthly monitor for compliance. (To be                           |                   |            |
|           | `                                                    | the certification period of  |                            |          | by 8/25/17)                                                                           | <del>-</del> giii |            |
|           | 4/9/17 to 6/7/17.                                    | -                            |                            |          | Director of Nursing/designee v                                                        | vill              |            |
|           | 7/ <i>/</i> /1/ 10 0///1/.                           |                              |                            |          |                                                                                       |                   |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 169 of 247

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                    | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |                            |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------|
|                                                                                                             | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                   |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                  |                                                                                     | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                   | (X5)<br>COMPLETION<br>DATE |
|                                                                                                             | aide services up days per week. I failed to be patie the minimal hou health aide to be would determine in a day should the needed for the B. The plan nursing to obtain needed. The plaindicate when to saturations.  C. A home a.m., was conducted aughters home been residing. The residence was not care. The plan of address where seep provided. During health aide indictive with the son daughter for a log remember when the home health the daughter was a side of the provided. The home health the daughter was a side of the plan of the p | of care indicated skilled a oxygen saturations as an of care failed to obtain oxygen  visit on 6/1/17 at 9:15 cted at the patient's where the patient had the new address of ot listed on the plan of of care included a former cryices were initially ng this time, the home atted the patient use to but moved in with the dibeen residing with the ng time and could not the patient had moved. |                                                                                     |                    | instruct nurses to indicate on For Care the following: the correaddress, status of others living the home, what tasks are to be provided by staff and when(nursing/aide). (To be completed by 8/25/17)  Director of Nursing will be responsible to ensure newly hinurses are trained to indicate of Plan of Care the following: the correct address, status of othe living in the home, what tasks to be provided by staff and who (nursing/aide). (To be begin by 8/25/17)  Director of Nursing/designee wadit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address tatus of others living in the home, what tasks are to be provided by staff and when(nursing/aide). Once 100 compliance is achieved, Direct of Nursing/designee will audit 25% of Plans of Care monthly monitor for compliance. (To be by 8/25/17)  Director of Nursing/designee winstruct nurses that a verbal or is needed from MD to make exvisits that fall outside the order visit frequency for that disciplir of the Plan of Care. (To be completed by 8/25/17)  Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal or from MD to make extra visits that fall outside the order visit frequency for that discipling the Plan of Care. (To be completed by 8/25/17)  Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal or from MD to make extra visits that fall outside the order visit frequency for that discipling the Plan of Care. (To be completed by 8/25/17) | red on are en / vill of e sess, % tor to egin will order on order |                            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE |      |          |                                                                                                    |        |            |
|------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------|------|----------|----------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                  | IDENTIFICATION NUMBER:                     |      | JILDING  | 00                                                                                                 | COMPL  | ETED       |
|                                                      |                                                                                | 15K064                                     | B. W | ING      |                                                                                                    | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                                           |                                            | _    | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                     |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIER                                                           |                                            |      | 6525 E   | 82ND ST STE 216                                                                                    |        |            |
| AT HOM                                               | E HEALTH SERVIC                                                                | CES LLC                                    |      | INDIAN   | APOLIS, IN 46250                                                                                   |        |            |
| (X4) ID                                              |                                                                                | TATEMENT OF DEFICIENCIES                   |      | ID       | PROVIDER'S PLAN OF CORRECTION                                                                      |        | (X5)       |
| PREFIX                                               | `                                                                              | ICY MUST BE PRECEDED BY FULL               |      | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | ГЕ     | COMPLETION |
| TAG                                                  |                                                                                | L LSC IDENTIFYING INFORMATION)             | +    | TAG      |                                                                                                    |        | DATE       |
|                                                      |                                                                                | ncluded a plan of care                     |      |          | fall outside the ordered visit<br>frequency for that discipline of                                 | the    |            |
|                                                      | with orders for skilled nursing every 14                                       |                                            |      |          | Plan of Care. (To begin by                                                                         | uie    |            |
|                                                      | _                                                                              | tion set up, oxygen                        |      |          | 8/25/17)                                                                                           |        |            |
|                                                      | saturations as ne                                                              | eded and home health                       |      |          | Director of Nursing/designee w                                                                     |        |            |
|                                                      | aide services up                                                               | to 8 hours per day, 7                      |      |          | track all nursing visits for a mo                                                                  | nth    |            |
|                                                      | days a week.                                                                   |                                            |      |          | to monitor for compliance with following ordered frequency ar                                      | nd if  |            |
|                                                      |                                                                                |                                            |      |          | extra visits are noted there is a                                                                  |        |            |
|                                                      | A. On 5/31                                                                     | /17 at 3:00 p.m.,                          |      |          | verbal order for that visit. Once                                                                  |        |            |
|                                                      | Employee C, the                                                                | e Interim Assistant                        |      |          | 100% compliance is achieved,                                                                       |        |            |
|                                                      | Director of Clinical Services, indicated she would make extra visits to the    |                                            |      |          | Director of Nursing will track 2                                                                   |        |            |
|                                                      |                                                                                |                                            |      |          | of patients monthly to monitor                                                                     | tor    |            |
|                                                      | patient's home to fix the medication box due to medications not being refilled |                                            |      |          | compliance. (To begin by 8/25/17)                                                                  |        |            |
|                                                      |                                                                                |                                            |      |          | Director of Nursing is responsi                                                                    | ble    |            |
|                                                      | before her visit.                                                              |                                            |      |          | for monitoring these corrective                                                                    |        |            |
|                                                      |                                                                                |                                            |      |          | actions to ensure that this                                                                        |        |            |
|                                                      | B On 5/31/                                                                     | /17 at 4:10 p.m.,                          |      |          | deficiency is corrected and will not recur.                                                        |        |            |
|                                                      |                                                                                | icated she was going to                    |      |          | not recur.                                                                                         |        |            |
|                                                      |                                                                                | 's home that evening and                   |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | atient had his / her                       |      |          |                                                                                                    |        |            |
|                                                      | _                                                                              | our home visit on 6/1/17.                  |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | our nome visit on 0/1/1/.                  |      |          |                                                                                                    |        |            |
|                                                      | C. On 6/2/1                                                                    | 7 at 4:45 p.m., Employee                   |      |          |                                                                                                    |        |            |
|                                                      | C indicated she                                                                | did not obtain orders nor                  |      |          |                                                                                                    |        |            |
|                                                      | did she complete                                                               | e nursing visit notes.                     |      |          |                                                                                                    |        |            |
|                                                      | D D :                                                                          | . C.d 1 1 1.1 1                            |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | of the home health aide                    |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | 03/29, 4/4, 4/9, 4/21,                     |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | /18, and 5/23/17, the                      |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | e provided services                        |      |          |                                                                                                    |        |            |
|                                                      | approximately fi                                                               | rom 3 hours to 7 hours.                    |      |          |                                                                                                    |        |            |
|                                                      | The plan of care                                                               | failed to be updated to                    |      |          |                                                                                                    |        |            |
|                                                      | _                                                                              | sits for skilled nursing in                |      |          |                                                                                                    |        |            |
|                                                      | the management                                                                 | _                                          |      |          |                                                                                                    |        |            |
|                                                      |                                                                                | r                                          | 1    |          |                                                                                                    |        |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                       | (X2) M                                                      | ULTIPLE CO | NSTRUCTION    | (X3) DATE                                                                              | SURVEY |                    |
|------------------------------------------------------|---------------------------------------|-------------------------------------------------------------|------------|---------------|----------------------------------------------------------------------------------------|--------|--------------------|
| AND PLAN                                             | OF CORRECTION                         | IDENTIFICATION NUMBER:                                      | A. BU      | JILDING       | 00                                                                                     | COMPL  | ETED               |
|                                                      |                                       | 15K064                                                      | B. W       | ING           |                                                                                        | 06/05/ | /2017              |
| NAME OF I                                            | DROVIDED OD CUDDI IEI                 |                                                             |            | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                                         |        |                    |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                  |                                                             |            | 6525 E        | 82ND ST STE 216                                                                        |        |                    |
| AT HOM                                               | E HEALTH SERVIC                       |                                                             |            | INDIAN        | APOLIS, IN 46250                                                                       |        |                    |
| (X4) ID                                              |                                       | TATEMENT OF DEFICIENCIES                                    |            | ID            | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)               |
| PREFIX<br>TAG                                        | `                                     | ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION) |            | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION<br>DATE |
| TAG                                                  |                                       | between scheduled visits,                                   |            | TAG           |                                                                                        |        | DATE               |
|                                                      |                                       | e health aide hours failed                                  |            |               |                                                                                        |        |                    |
|                                                      | to be patient specific to include the |                                                             |            |               |                                                                                        |        |                    |
|                                                      |                                       |                                                             |            |               |                                                                                        |        |                    |
|                                                      | _                                     | er day for the home                                         |            |               |                                                                                        |        |                    |
|                                                      |                                       | in the home as well as rmined the duration of               |            |               |                                                                                        |        |                    |
|                                                      |                                       |                                                             |            |               |                                                                                        |        |                    |
|                                                      | _                                     | nould the home health ed for the entire 8 hours             |            |               |                                                                                        |        |                    |
|                                                      |                                       |                                                             |            |               |                                                                                        |        |                    |
|                                                      | and when to obta                      | ain oxygen saturations.                                     |            |               |                                                                                        |        |                    |
|                                                      | 3. The clinical r                     | record for patient #4,                                      |            |               |                                                                                        |        |                    |
|                                                      | SOC 4/24/17, in                       | cluded a plan of care for                                   |            |               |                                                                                        |        |                    |
|                                                      | the certification                     | period of 4/24/17 to                                        |            |               |                                                                                        |        |                    |
|                                                      | 6/22/17, with or                      | ders for a LPN (licensed                                    |            |               |                                                                                        |        |                    |
|                                                      | practical nurse)                      | up to 3 hours per day, 5                                    |            |               |                                                                                        |        |                    |
|                                                      | days a week to a                      | assist with personal care,                                  |            |               |                                                                                        |        |                    |
|                                                      | transfers, medica                     | ation reminders, meal                                       |            |               |                                                                                        |        |                    |
|                                                      | preparation / set                     | up, and light                                               |            |               |                                                                                        |        |                    |
|                                                      | housekeeping.                         | The plan of care also                                       |            |               |                                                                                        |        |                    |
|                                                      | indicated for the                     | skilled nurse to obtain                                     |            |               |                                                                                        |        |                    |
|                                                      | oxygen saturatio                      | ons as needed.                                              |            |               |                                                                                        |        |                    |
|                                                      |                                       |                                                             |            |               |                                                                                        |        |                    |
|                                                      | 1                                     | home visit on 6/1/17 at                                     |            |               |                                                                                        |        |                    |
|                                                      |                                       | Employee E, a LPN, was                                      |            |               |                                                                                        |        |                    |
|                                                      |                                       | inister liquid dilantin                                     |            |               |                                                                                        |        |                    |
|                                                      | `                                     | dication), tylenol and                                      |            |               |                                                                                        |        |                    |
|                                                      |                                       | for mild pain and / or                                      |            |               |                                                                                        |        |                    |
|                                                      |                                       | eximately 100 ml                                            |            |               |                                                                                        |        |                    |
|                                                      | ,                                     | rater flush through the                                     |            |               |                                                                                        |        |                    |
|                                                      | patient's gastric                     | tube (g-tube) before,                                       |            |               |                                                                                        |        |                    |
|                                                      | during, and after                     |                                                             |            |               |                                                                                        |        |                    |
|                                                      | administration.                       | In the kitchen, a piece of                                  |            |               |                                                                                        |        |                    |
|                                                      | paper that was so                     | ecured to a cabinet door                                    |            |               |                                                                                        |        |                    |
|                                                      | contained a list of                   | of medications and water                                    |            |               |                                                                                        |        |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 172 of 247

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                  |                      |
|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                             | PROVIDER OR SUPPLIEF<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                                 |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                                                                             | Employee E ind sometimes have administered pri sometimes the c to administer. E would provide g patient received the patient discuvent and bypap rescue.  B. Review of notes indicated to the patient discuvent and bypap rescue.  B. Review of notes indicated to the patient discuvent and bypap rescue.  1. On 4 5/5, 5/8, 5/9, 5/1 5/17,5/18, 5/22, 5/31, 6/1 and 6/2 indicated the ski tube feedings and tube feedings per growth ame, amount, a feedings per growth oxygen saturation saturation and the same | or to their arrival and linical staff would have imployee E indicated shetube site care after the a bath. Employee E and seed using the Trilogy machine for oxygen  of the skilled nursing visit he following:  /27, 4/28, 5/2, 5/3, 5/4, 0, 5/11, 5/15, 5/16, 5/23, 5/24, 5/25, 5/30, 2/17, the visit notes lled nurse administered d water flushes.  /25, 5/30, 5/31, 6/1 and notes indicated the ovided g-tube site care.  failed to be updated to atter flushes per g-tube, the and frequency of tube abe, when to obtain ons, and instruction on the ty yent and bypap |                     |                                                                                                                        |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 173 of 247

|               |                      | l í                                                        |      | NSTRUCTION    | (X3) DATE                                                          |        |                    |
|---------------|----------------------|------------------------------------------------------------|------|---------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN      | OF CORRECTION        | IDENTIFICATION NUMBER:                                     |      | JILDING       | 00                                                                 | COMPL  |                    |
|               |                      | 15K064                                                     | B. W | ing           |                                                                    | 06/05/ | 2017               |
| NAME OF I     | PROVIDER OR SUPPLIEF | ₹                                                          |      |               | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
|               |                      | STOLL C                                                    |      |               | 82ND ST STE 216                                                    |        |                    |
|               | E HEALTH SERVIC      |                                                            |      | INDIAN        | APOLIS, IN 46250                                                   |        |                    |
| (X4) ID       |                      | TATEMENT OF DEFICIENCIES                                   |      | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| PREFIX<br>TAG | 1                    | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) |      | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | TE     | COMPLETION<br>DATE |
| TAG           | REGULATORT OR        | LESC IDENTIFTING INFORMATION)                              |      | TAG           |                                                                    |        | DATE               |
|               | 1 The clinical r     | record for patient #5,                                     |      |               |                                                                    |        |                    |
|               |                      | ncluded a plan of care for                                 |      |               |                                                                    |        |                    |
|               | 1                    | -                                                          |      |               |                                                                    |        |                    |
|               |                      | period of 3/19/17 to                                       |      |               |                                                                    |        |                    |
|               |                      | ders for home health aide                                  |      |               |                                                                    |        |                    |
|               | •                    | hours per day, 5 days a                                    |      |               |                                                                    |        |                    |
|               | week.                |                                                            |      |               |                                                                    |        |                    |
|               | A Dovious            | of the home health aide                                    |      |               |                                                                    |        |                    |
|               |                      |                                                            |      |               |                                                                    |        |                    |
|               |                      | g this certification<br>e health aide provided             |      |               |                                                                    |        |                    |
|               |                      | •                                                          |      |               |                                                                    |        |                    |
|               |                      | mately from 1.25 to 3                                      |      |               |                                                                    |        |                    |
|               |                      | tions of hours failed to                                   |      |               |                                                                    |        |                    |
|               |                      | ic and include the                                         |      |               |                                                                    |        |                    |
|               | _                    | er day for the home                                        |      |               |                                                                    |        |                    |
|               |                      | in the home and who                                        |      |               |                                                                    |        |                    |
|               |                      | ed the duration of hours                                   |      |               |                                                                    |        |                    |
|               | <u>-</u>             | the home health aide not                                   |      |               |                                                                    |        |                    |
|               | be needed for the    | e entire 6 hours.                                          |      |               |                                                                    |        |                    |
|               |                      |                                                            |      |               |                                                                    |        |                    |
|               | _                    | of care indicated skilled                                  |      |               |                                                                    |        |                    |
|               | _                    | n oxygen saturations as                                    |      |               |                                                                    |        |                    |
|               | _                    | n of care failed to                                        |      |               |                                                                    |        |                    |
|               | indicate when to     | obtain oxygen                                              |      |               |                                                                    |        |                    |
|               | saturations.         |                                                            |      |               |                                                                    |        |                    |
|               | 5 Th1' ' 1           | and formations III                                         |      |               |                                                                    |        |                    |
|               |                      | record for patient #6,                                     |      |               |                                                                    |        |                    |
|               |                      | ncluded a plan of care for                                 |      |               |                                                                    |        |                    |
|               |                      | period of 3/31/17 to                                       |      |               |                                                                    |        |                    |
|               |                      | ders for skilled nursing 1                                 |      |               |                                                                    |        |                    |
|               |                      | to 2 hours per visit, 3                                    |      |               |                                                                    |        |                    |
|               | _                    | for the instillation of                                    |      |               |                                                                    |        |                    |
|               |                      | gation solution via                                        |      |               |                                                                    |        |                    |
|               | catheter into bla    | dder every visit. The                                      |      |               |                                                                    |        |                    |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) M                                                                                                    | ULTIPLE CO | NSTRUCTION | (X3) DATE                                                                              | SURVEY |            |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------|------------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IDENTIFICATION NUMBER:                                                                                    | A. BU      | JILDING    | 00                                                                                     | COMPL  | ETED       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15K064                                                                                                    | B. W       | ING        |                                                                                        | 06/05/ | 2017       |
| NAME OF B                                            | DOMDED OD GLIDDI IEI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |            | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                                         |        |            |
| NAME OF P                                            | ROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | C                                                                                                         |            | 6525 E     | 82ND ST STE 216                                                                        |        |            |
|                                                      | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES                                                                                  |            | ID         | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)       |
| PREFIX                                               | *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CY MUST BE PRECEDED BY FULL                                                                               |            | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | LSC IDENTIFYING INFORMATION)                                                                              | +          | TAG        | DEFICIENCE                                                                             |        | DATE       |
|                                                      | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ile evidenced Clorpactin                                                                                  |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ed every Monday,                                                                                          |            |            |                                                                                        |        |            |
|                                                      | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Friday via urostomy                                                                                       |            |            |                                                                                        |        |            |
|                                                      | flush and order f                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | for skilled nursing to                                                                                    |            |            |                                                                                        |        |            |
|                                                      | obtain oxygen sa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | aturations as needed.                                                                                     |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      | A. Review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | of the skilled nursing visit                                                                              |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | /3, 4/5, 4/7, 4/10, 4/12,                                                                                 |            |            |                                                                                        |        |            |
|                                                      | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4/21, 4/24, 4/26, 4/28,                                                                                   |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5, 5/10, 5/12, 5/15, 5/17,                                                                                |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5/26, and 5/29/17, the                                                                                    |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | to evidence that the                                                                                      |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | e medication / irrigation                                                                                 |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | eter into the bladder had                                                                                 |            |            |                                                                                        |        |            |
|                                                      | been provided                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      | R The Dire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ector of Clinical Services                                                                                |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | on 06/05/17 at 1:30 and                                                                                   |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | eient's Clorpactin                                                                                        |            |            |                                                                                        |        |            |
|                                                      | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | -                                                                                                         |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      | discontinue the (                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Clorpactin instillation.                                                                                  |            |            |                                                                                        |        |            |
|                                                      | C A Dysmin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | na a hama vigit an 6/2/17                                                                                 |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | _                                                                                                         |            |            |                                                                                        |        |            |
|                                                      | · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | •                                                                                                         |            |            |                                                                                        |        |            |
|                                                      | live in a group h                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ome.                                                                                                      |            |            |                                                                                        |        |            |
|                                                      | The plan of care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | failed to be updated to                                                                                   |            |            |                                                                                        |        |            |
|                                                      | exclude the Clor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | pactin medication                                                                                         |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | *                                                                                                         |            |            |                                                                                        |        |            |
|                                                      | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |            |            |                                                                                        |        |            |
|                                                      | discontinued. The Services provided order dated 3/2/1 discontinue the Continue the Continue the Continue the Service in a group has a grou | clorpactin instillation.  ng a home visit on 6/2/17 patient was observed to ome.  failed to be updated to |            |            |                                                                                        |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 175 of 247

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                             | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                       | ONSTRUCTION 00      | COMPLE                                                                                                       | (X3) DATE SURVEY COMPLETED 06/05/2017 |                            |
|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
|                                                                                                             | PROVIDER OR SUPPLIEF                                                                                                                                        |                                                                                                                                                                                                                                                  | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                     |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN                                                                                                                                              | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE                                   | (X5)<br>COMPLETION<br>DATE |
|                                                                                                             | and received ser home.                                                                                                                                      | vices within a group                                                                                                                                                                                                                             |                     |                                                                                                              |                                       |                            |
|                                                                                                             | SOC 12/31/16, i<br>the certification<br>6/7/17, with order                                                                                                  | ecord for patient #7,<br>ncluded a plan of care for<br>period of 4/9/17 to<br>ers for home health aide<br>hours per day, 7 days a                                                                                                                |                     |                                                                                                              |                                       |                            |
|                                                                                                             | visit notes during period, the home services approxionate hours. The durate be patient specific minimal hours purchasting health aide to be would determine | of the home health aide g this certification health aide provided mately from 3.5 to 6 tions of hours failed to fic and include the er day for the home in the home and who had the duration of hours he home health aide not he entire 6 hours. |                     |                                                                                                              |                                       |                            |
|                                                                                                             | nursing to obtain                                                                                                                                           | of care indicated skilled<br>n oxygen saturations as<br>n of care failed to<br>obtain oxygen                                                                                                                                                     |                     |                                                                                                              |                                       |                            |
|                                                                                                             | comprehensive a<br>the "Professiona<br>section indicated<br>receiving home                                                                                  | of a recertification assessment dated 4/7/17, and Services" narrative at the patient was the health services with a sy for wound treatments.                                                                                                     |                     |                                                                                                              |                                       |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 176 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                              | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING 00 COMPLETED |               |        |                                                                                        |        |            |
|------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------|---------------|--------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                | IDENTIFICATION NUMBER:  15K064                                       | A. BU<br>B. W |        | 00                                                                                     | 06/05/ |            |
|                                                      |                                                              | 150004                                                               | D. W.         |        |                                                                                        | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                         | 8                                                                    |               |        | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                      |        |            |
| AT HOM                                               | E HEALTH SERVIC                                              | CES LLC                                                              |               |        | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID                                              |                                                              | TATEMENT OF DEFICIENCIES                                             |               | ID     | PROVIDER'S PLAN OF CORRECTION                                                          |        |            |
| PREFIX                                               | `                                                            | ICY MUST BE PRECEDED BY FULL                                         |               | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE     | COMPLETION |
| TAG                                                  |                                                              | LSC IDENTIFYING INFORMATION)                                         |               | TAG    | DEFICIENC!)                                                                            |        | DATE       |
|                                                      |                                                              | failed to evidence that                                              |               |        |                                                                                        |        |            |
|                                                      | the patient's wounds were being managed by a Medicare agency |                                                                      |               |        |                                                                                        |        |            |
|                                                      | by a Medicare agency.                                        |                                                                      |               |        |                                                                                        |        |            |
|                                                      | 7 The clinical r                                             | record for patient #8,                                               |               |        |                                                                                        |        |            |
|                                                      |                                                              | luded a plan of care for                                             |               |        |                                                                                        |        |            |
|                                                      |                                                              | period of 3/31/17 to                                                 |               |        |                                                                                        |        |            |
|                                                      |                                                              | ders for home health aide                                            |               |        |                                                                                        |        |            |
|                                                      | ·                                                            | hours per day, 7 days a                                              |               |        |                                                                                        |        |            |
|                                                      | week.                                                        | neons per any, , any a                                               |               |        |                                                                                        |        |            |
|                                                      |                                                              |                                                                      |               |        |                                                                                        |        |            |
|                                                      | A. Review of the home health aide                            |                                                                      |               |        |                                                                                        |        |            |
|                                                      | visit notes during                                           | g this certification                                                 |               |        |                                                                                        |        |            |
|                                                      |                                                              | e health aide provided                                               |               |        |                                                                                        |        |            |
|                                                      | _                                                            | mately from 3.50 to 8                                                |               |        |                                                                                        |        |            |
|                                                      |                                                              | tions of hours failed to                                             |               |        |                                                                                        |        |            |
|                                                      | be patient specif                                            | ic and include the                                                   |               |        |                                                                                        |        |            |
|                                                      | minimal hours p                                              | er day for the home                                                  |               |        |                                                                                        |        |            |
|                                                      | health aide to be                                            | in the home and who                                                  |               |        |                                                                                        |        |            |
|                                                      | would determine                                              | ed the duration of hours                                             |               |        |                                                                                        |        |            |
|                                                      | in a day should t                                            | he home health aide not                                              |               |        |                                                                                        |        |            |
|                                                      | be needed for the                                            | e entire 8 hours.                                                    |               |        |                                                                                        |        |            |
|                                                      |                                                              |                                                                      |               |        |                                                                                        |        |            |
|                                                      |                                                              | of care indicated skilled                                            |               |        |                                                                                        |        |            |
|                                                      |                                                              | n oxygen saturations as                                              |               |        |                                                                                        |        |            |
|                                                      | _                                                            | n of care failed to                                                  |               |        |                                                                                        |        |            |
|                                                      | indicate when to                                             | obtain oxygen                                                        |               |        |                                                                                        |        |            |
|                                                      | saturations.                                                 |                                                                      |               |        |                                                                                        |        |            |
|                                                      | 8. Employee B,                                               | the Director of Clinical                                             |               |        |                                                                                        |        |            |
|                                                      | Services and Em                                              | ployee C, the Interim                                                |               |        |                                                                                        |        |            |
|                                                      | Alternate Direct                                             | or of Clinical Services,                                             |               |        |                                                                                        |        |            |
|                                                      | had no further in                                            | formation or                                                         |               |        |                                                                                        |        |            |
|                                                      | documentation is                                             | n relation to the above                                              |               |        |                                                                                        |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 177 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                  | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                                                                                                                  |                      |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                             | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>JAPOLIS, IN 46250                                                                                                                                                 |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                                                                                                  | (X5) COMPLETION DATE |
|                                                                                                            | further information the exit conference of the exit conference of the exit conference of the exit conference of the exit communication is required in the admission, recerchange in the plan of Care is but assessment and if the client / family member The I completed in full frequency, and desired the exit conference of the exit conference o | the Alternate and Employee B, had no son or documentation by ace on 6/5/17 at 3:50 p.m.                                     |                     |                                                                                                                                                                                                                        |                      |
| N 0527<br>Bldg. 00                                                                                         | professional staff<br>shall promptly aler<br>for the medical co                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | o(2) The health care of the home health agency rt the person responsible mponent of the patient's es that suggest a need to |                     |                                                                                                                                                                                                                        |                      |
|                                                                                                            | the agency failed<br>physician was no<br>discharge in 1 of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | review and interview, I to ensure that the otified of a patient's early 2 records reviewed of outs in a sample of 10.       | N 0527              | Director of Nursing will in-sen nursing staff on requirement to notify MD of a patient's dischand notifying any other agencinvolved in patient's care of upcoming discharge of patient from agency. Nurses to document | o arge<br>ty         |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 178 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                            | (X2) MULTIPLE CONSTRUCTION                                  |       |               | (X3) DATE SURVEY                                                   |        |                    |
|------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------|-------|---------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN                                             | OF CORRECTION                              | IDENTIFICATION NUMBER:                                      | A. BU | JILDING       | 00                                                                 | COMPL  | ETED               |
|                                                      |                                            | 15K064                                                      | B. W  | NG            |                                                                    | 06/05/ | 2017               |
|                                                      |                                            |                                                             |       | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
| NAME OF F                                            | PROVIDER OR SUPPLIEF                       | 8                                                           |       |               | 82ND ST STE 216                                                    |        |                    |
| AT HOM                                               | E HEALTH SERVIC                            | CESTIC                                                      |       |               | APOLIS, IN 46250                                                   |        |                    |
|                                                      |                                            |                                                             |       |               | 711 0210, 114 10200                                                |        |                    |
| (X4) ID                                              |                                            | TATEMENT OF DEFICIENCIES                                    |       | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| PREFIX<br>TAG                                        | `                                          | ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION) |       | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                     | ΓE     | COMPLETION<br>DATE |
| IAU                                                  | REGULATORT OR                              | LESC IDENTIFTING INFORMATION)                               |       | IAU           | these conversations in patient                                     |        | DATE               |
|                                                      |                                            |                                                             |       |               | chart. (To be completed by                                         | 3      |                    |
|                                                      | Findings include                           | 2:                                                          |       |               | 8/25/17)                                                           |        |                    |
|                                                      |                                            |                                                             |       |               | Director of Nursing will be                                        |        |                    |
|                                                      | 1. The clinical record for #10, SOC (start |                                                             |       |               | responsible to ensure orientati                                    |        |                    |
|                                                      | of care) 5/11/16,                          | , was reviewed and                                          |       |               | of newly hired nurses includes                                     |        |                    |
|                                                      | included a plan                            | of care for the                                             |       |               | training on requirement to noti                                    |        |                    |
|                                                      | certification of 3                         | 5/7/17 to 5/5/17, with                                      |       |               | MD of a patient's discharge ar notifying any other agency          | u      |                    |
|                                                      | orders for home                            | health aide services up to                                  |       |               | involved in patient's care of                                      |        |                    |
|                                                      |                                            | lays a week to assist with                                  |       |               | upcoming discharge of patient                                      |        |                    |
|                                                      | personal care, ba                          | athing, dressing, activities                                |       |               | from agency. Nurses to docum                                       |        |                    |
|                                                      |                                            | neal prep, medication                                       |       |               | these conversations in patient                                     | S      |                    |
|                                                      | '                                          | ght housekeeping per                                        |       |               | chart. (To begin by 8/25/17) Director of Nursing/designee v        | /ill   |                    |
|                                                      | care plan.                                 | ght housekeeping per                                        |       |               | audit 100% of discharges to                                        | 7111   |                    |
|                                                      | care plan.                                 |                                                             |       |               | ensure compliance with notifyi                                     | ng     |                    |
|                                                      | A The alim                                 |                                                             |       |               | MD of upcoming discharge an                                        | •      |                    |
|                                                      |                                            | ical record evidenced a                                     |       |               | notifying other agencies involv                                    | ed     |                    |
|                                                      |                                            | S discharge assessment                                      |       |               | in patient's care of patient's                                     |        |                    |
|                                                      |                                            | ne clinical record failed                                   |       |               | upcoming discharge from agei<br>(To begin by 8/25/17)              | icy.   |                    |
|                                                      |                                            | t the attending physician                                   |       |               | The Director of Nursing will be                                    |        |                    |
|                                                      | had been notified                          | •                                                           |       |               | responsible for monitoring the                                     |        |                    |
|                                                      | unscheduled disc                           | charge.                                                     |       |               | corrective actions to ensure th                                    |        |                    |
|                                                      |                                            |                                                             |       |               | this deficiency is corrected and                                   | t      |                    |
|                                                      | 2. An interview                            | with the Employee C,                                        |       |               | will not recur.                                                    |        |                    |
|                                                      | Interim Director                           | of Clinical Services, on                                    |       |               |                                                                    |        |                    |
|                                                      | 5/31/17 at 2:30 p                          | o.m., the employee                                          |       |               |                                                                    |        |                    |
|                                                      | indicated the pat                          | ient would send aides                                       |       |               |                                                                    |        |                    |
|                                                      | home but one da                            | y, the patient called and                                   |       |               |                                                                    |        |                    |
|                                                      |                                            | r home health agency                                        |       |               |                                                                    |        |                    |
|                                                      |                                            | . At Home Health                                            |       |               |                                                                    |        |                    |
|                                                      |                                            | to discharge the patient.                                   |       |               |                                                                    |        |                    |
|                                                      | 201 11003 4001400                          | . to anomarge the patient.                                  |       |               |                                                                    |        |                    |
|                                                      | 3 On 5/21/17 or                            | t 2:30 n m the agency                                       |       |               |                                                                    |        |                    |
|                                                      |                                            | t 2:30 p.m., the agency                                     |       |               |                                                                    |        |                    |
|                                                      | _                                          | ovide any further                                           |       |               |                                                                    |        |                    |
|                                                      |                                            | uch as physician orders                                     |       |               |                                                                    |        |                    |
|                                                      | or coordination i                          | notes with the physician                                    |       |               |                                                                    |        |                    |

| STATEMENT OF DEFICIENCIES X |                                    | X1) PROVIDER/SUPPLIER/CLIA                        | (X2) M | ULTIPLE CO             | NSTRUCTION                                                                             | (X3) DATE SURVEY |                    |
|-----------------------------|------------------------------------|---------------------------------------------------|--------|------------------------|----------------------------------------------------------------------------------------|------------------|--------------------|
| AND PLAN                    | OF CORRECTION                      | IDENTIFICATION NUMBER:                            | A. BU  | JILDING                | 00                                                                                     | COMPL            | ETED               |
|                             |                                    | 15K064                                            | B. WI  | NG                     |                                                                                        | 06/05/           | 2017               |
| NAME OF P                   | ROVIDER OR SUPPLIER                |                                                   |        | STREET A               | ADDRESS, CITY, STATE, ZIP CODE                                                         | <u> </u>         |                    |
|                             |                                    |                                                   |        |                        | 82ND ST STE 216                                                                        |                  |                    |
| AT HOME                     | E HEALTH SERVIC                    | ES LLC                                            |        | INDIANAPOLIS, IN 46250 |                                                                                        |                  |                    |
| (X4) ID                     |                                    | TATEMENT OF DEFICIENCIES                          |        | ID                     | PROVIDER'S PLAN OF CORRECTION                                                          |                  | (X5)               |
| PREFIX<br>TAG               |                                    | CY MUST BE PRECEDED BY FULL                       |        | PREFIX<br>TAG          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE               | COMPLETION<br>DATE |
| TAG                         |                                    | LSC IDENTIFYING INFORMATION)                      |        | TAG                    | BELLOEIN                                                                               |                  | DATE               |
|                             | in regards to the                  | discharge upon request.                           |        |                        |                                                                                        |                  |                    |
|                             | 4 An undated n                     | olicy titled "Physician                           |        |                        |                                                                                        |                  |                    |
|                             | Orders" C - 635,                   | -                                                 |        |                        |                                                                                        |                  |                    |
|                             |                                    | with a patient's physician                        |        |                        |                                                                                        |                  |                    |
|                             |                                    | following cases: Upon                             |        |                        |                                                                                        |                  |                    |
|                             | -                                  | tification or discharge                           |        |                        |                                                                                        |                  |                    |
|                             | change in the pla                  | •                                                 |        |                        |                                                                                        |                  |                    |
|                             | change in the pic                  | an or care                                        |        |                        |                                                                                        |                  |                    |
| N 0529                      | 410 IAC 17-13-1(a                  | a)(2)                                             |        |                        |                                                                                        |                  |                    |
|                             | Patient Care                       | (O) A (U                                          |        |                        |                                                                                        |                  |                    |
| Bldg. 00                    |                                    | (2) A written summary tient shall be sent to the: |        |                        |                                                                                        |                  |                    |
|                             | (A) physician;                     | tient shall be sent to the.                       |        |                        |                                                                                        |                  |                    |
|                             | (B) dentist;                       |                                                   |        |                        |                                                                                        |                  |                    |
|                             | (C) chiropractor;                  |                                                   |        |                        |                                                                                        |                  |                    |
|                             | (D) optometrist or                 | •                                                 |        |                        |                                                                                        |                  |                    |
|                             | (E) podiatrist; at least every two | (2) months                                        |        |                        |                                                                                        |                  |                    |
|                             |                                    | review and interview,                             | N 0    | 529                    | Director of Nursing will in-serv                                                       | ice              | 08/25/2017         |
|                             |                                    | I to ensure 60 day                                |        |                        | nurses on ensuring correct                                                             |                  |                    |
|                             |                                    | reflective of the patients                        |        |                        | information, to include correct                                                        |                  |                    |
|                             |                                    | s goals being met and not                         |        |                        | address and status of any<br>caregivers – disabled, refuse t                           | ·O               |                    |
|                             |                                    | out of 7 active records                           |        |                        | assist, etc, is on patient's Plan                                                      |                  |                    |
|                             |                                    | ents with recertifications                        |        |                        | Care. (To be done by 8/25/17)                                                          | )                |                    |
|                             | _                                  | ). (#2, 3, 5 and 6)                               |        |                        | Director of Nursing will in-serv                                                       |                  |                    |
|                             | a sample of 10                     | (2, 5, 5 and 6)                                   |        |                        | nurses on proper way to write<br>day summaries. Summaries a                            |                  |                    |
|                             | Findings include                   | ÷                                                 |        |                        | to be updated each recertificat                                                        |                  |                    |
|                             | i mamgs merade                     | •                                                 |        |                        | to reflect patient's actual status                                                     |                  |                    |
|                             | 1 The clinical r                   | ecord for patient #2,                             |        |                        | for the previous certification                                                         |                  |                    |
|                             |                                    | re) 03/06/12, was                                 |        |                        | period. This includes discussir                                                        | ng               |                    |
|                             | •                                  | cluded a plan of care for                         |        |                        | progress toward goals set for patient. (To be completed by                             |                  |                    |
|                             |                                    | period of 2/8/17 to                               |        |                        | 8/25/17)                                                                               |                  |                    |
|                             | •                                  | 7 to 6/7/17. The goals                            |        |                        | Director of Nursing will be                                                            |                  |                    |
|                             |                                    | •                                                 |        |                        | responsible to ensure orientati                                                        |                  |                    |
|                             |                                    | lient's safety will be                            |        |                        | of newly hired nurses includes<br>instruction on ensuring Plan of                      |                  |                    |
|                             | cimanceu unoug                     | h the home care services                          |        |                        | Care reflects correct information                                                      |                  |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 180 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (1) COMPLETED |       |              |                                                                    |        |                    |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------|--------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN                                             | OF CORRECTION                                                                                                            | IDENTIFICATION NUMBER:                                                 |       |              | 00                                                                 | COMPL  |                    |
|                                                      |                                                                                                                          | 15K064                                                                 | B. W. | ING          |                                                                    | 06/05/ | 2017               |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                                                                                     | <b>t</b>                                                               |       |              | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
| AT LIOM                                              | E HEALTH SERVIC                                                                                                          | SEC II C                                                               |       |              | 82ND ST STE 216<br>APOLIS, IN 46250                                |        |                    |
|                                                      |                                                                                                                          |                                                                        |       |              | AF OLIS, IN 40250                                                  |        |                    |
| (X4) ID<br>PREFIX                                    |                                                                                                                          | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL                  |       | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)<br>COMPLETION |
| TAG                                                  | `                                                                                                                        | LSC IDENTIFYING INFORMATION)                                           |       | TAG          | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                      | ΓE     | DATE               |
|                                                      | AEB [as evidend                                                                                                          | ced by no falls / injuries                                             |       |              | and that 60 day summaries                                          |        |                    |
|                                                      |                                                                                                                          | nin cert period. The                                                   |       |              | reflect patient's actual status for                                |        |                    |
|                                                      |                                                                                                                          | mucous membranes will                                                  |       |              | the previous certification period                                  | d.     |                    |
|                                                      | remain intact. T                                                                                                         | he client's home                                                       |       |              | (To begin by 8/25/17) Director of Nursing/designee v               | /ill   |                    |
|                                                      | environment wil                                                                                                          | l be clean and safe,                                                   |       |              | audit 100% of 60 day summar                                        |        |                    |
|                                                      | hygiene and pers                                                                                                         | sonal care needs will be                                               |       |              | to monitor for compliance with                                     |        |                    |
|                                                      | met "                                                                                                                    |                                                                        |       |              | providing accurate summary o<br>patient's status, including        | I      |                    |
|                                                      |                                                                                                                          |                                                                        |       |              | progress towards goals, the pa                                     | ast    |                    |
|                                                      | A. A plan of care for the certification period of 02/08/17 to 04/08/17, included a 60 day summary that indicated "Client |                                                                        |       |              | cert period. Once 100%                                             |        |                    |
|                                                      |                                                                                                                          |                                                                        |       |              | compliance is achieved, Direct of Nursing/designee will audit      | or     |                    |
|                                                      |                                                                                                                          |                                                                        |       |              | 25% of 60 day summaries                                            |        |                    |
|                                                      | _                                                                                                                        | hensive assessment and                                                 |       |              | monthly to monitor for                                             |        |                    |
|                                                      | recertification of                                                                                                       | f HHA [home health                                                     |       |              | compliance. (To begin by                                           |        |                    |
|                                                      | _                                                                                                                        | lient to be recertified for                                            |       |              | 8/25/17).                                                          |        |                    |
|                                                      | _                                                                                                                        | of HHA services. Client                                                |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | e who lives with her son,                                              |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | de the home in one                                                     |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | th basement, requires 24                                               |       |              |                                                                    |        |                    |
|                                                      | ^                                                                                                                        | and assist with all                                                    |       |              |                                                                    |        |                    |
|                                                      | _                                                                                                                        | s of daily living] and                                                 |       |              |                                                                    |        |                    |
|                                                      | _                                                                                                                        | ental activities of daily                                              |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | is non ambulatory and                                                  |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | lue to] severe dementia.                                               |       |              |                                                                    |        |                    |
|                                                      | ' ' '                                                                                                                    | of End Stage Alzheimer's                                               |       |              |                                                                    |        |                    |
|                                                      | _                                                                                                                        | nypertension], urinary and                                             |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | nce, and impaired gait.  Bulatory and requires                         |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | athing, dressing, meal                                                 |       |              |                                                                    |        |                    |
|                                                      | · ·                                                                                                                      | athing, dressing, mean<br>il soft diet), set up and                    |       |              |                                                                    |        |                    |
|                                                      | feeding, medicat                                                                                                         | · -                                                                    |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | re and light housekeeping.                                             |       |              |                                                                    |        |                    |
|                                                      | Client lives with                                                                                                        |                                                                        |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | me outside the home and                                                |       |              |                                                                    |        |                    |
|                                                      |                                                                                                                          | ance to care for patient.                                              |       |              |                                                                    |        |                    |
|                                                      | 15 11000 01 055150                                                                                                       | mos to care for patient.                                               |       |              |                                                                    |        |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 181 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                                                                                                                                                                                                                                                                                                                                       |                     |                                                         | (X3) DATE SURVEY COMPLETED 06/05/2017                                                       |    |                            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------|----|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                        | 652                 | ET ADDRESS, CITY,<br>5 E 82ND ST STI<br>IANAPOLIS, IN 4 | E 216                                                                                       |    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | (EACH CORRE                                             | ER'S PLAN OF CORRECTION<br>ECTIVE ACTION SHOULD BE<br>ENCED TO THE APPROPRIA<br>DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            | bladder increasing breakdown, paties briefs. Caregive just had lunch. On when nurse arrived client had no charmedications, no hospitalizations. Clear, heart irregulation with a bodomen soft / no Pedal pulses palipatient unable to pounds. Family care / services particulated by patient unable to pounds. Family care / services particulated by a particulat | nent of bowel and ng the risk of skin ent does wear adult er present, stated patient Client asleep on sofa red, caregiver stated ange in condition, no new visits to ER / Lung sounds were ular, bowel sounds WNL imits] x 4 quads, non-tender to palpitation. pable, no edema noted to stand for height, Wt 76 reports satisfaction with rovided by agency. If |                     |                                                         |                                                                                             |    |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 182 of 247

|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIP<br>A. BUILDIN<br>B. WING |      | nstruction<br><u>00</u>                                                                                                | (X3) DATE :<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|------|------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 652                                  | 25 E | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                   |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFI<br>TAC                   |      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                             | (X5)<br>COMPLETION<br>DATE |
|                          | DX [diagnoses] Disease, HTN [h bowel incontinent Client is non-am total transfers, be prep (mechanical feeding, medicat incontinence car Client lives with employed full tit is need of assista Client is incontin bladder increasin breakdown, patie briefs. Caregive just had lunch. when nurse arriv client had no cha medications, no hospitalizations. clear, heart irreg [within normal 1 abdomen soft / n Pedal pulses pal patient unable to pounds. Family care / services pa Client's MD notic care with no cha  C. A home a.m., was conduct | of End Stage Alzheimer's hypertension], urinary and nee, and impaired gait. Ibulatory and requires athing, dressing, meal al soft diet), set up and tion reminders, the and light housekeeping. The son who is the outside the home and tione to care for patient. The neutron of bowel and the risk of skin the ent does wear adult the present, stated patient asleep on sofa ared, caregiver stated ange in condition, no new visits to ER /  Lung sounds were the ular, bowel sounds WNL timits] x 4 quads, the neutron of the ight, Wt 76 are ports satisfaction with the rovided by agency. The infect of the patient of the ight, who have to care plan." |                                      |      |                                                                                                                        |                                |                            |
|                          | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | where the patient had<br>he new address of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                      |      |                                                                                                                        |                                |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 183 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED |               |        |                                                                        |        |            |
|------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------|---------------|--------|------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                                       | IDENTIFICATION NUMBER:  15K064                                        | A. B.<br>B. W |        | 00                                                                     |        |            |
|                                                      |                                                                     | 13K004                                                                | Б. W          |        |                                                                        | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                                | 8                                                                     |               |        | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                      |        |            |
| AT HOM                                               | E HEALTH SERVIC                                                     | CES LLC                                                               |               |        | APOLIS, IN 46250                                                       |        |            |
| (X4) ID                                              | SUMMARY S                                                           | TATEMENT OF DEFICIENCIES                                              |               | ID     | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX                                               | `                                                                   | CY MUST BE PRECEDED BY FULL                                           |               | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                  |                                                                     | LSC IDENTIFYING INFORMATION)                                          |               | TAG    | DEFICIENCY)                                                            |        | DATE       |
|                                                      |                                                                     | ot listed on the plan of                                              |               |        |                                                                        |        |            |
|                                                      | _                                                                   | of care included a former                                             |               |        |                                                                        |        |            |
|                                                      | address where services were initially                               |                                                                       |               |        |                                                                        |        |            |
|                                                      | _                                                                   | ng this time, the home                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     | ated the patient use to                                               |               |        |                                                                        |        |            |
|                                                      |                                                                     | but moved in with the                                                 |               |        |                                                                        |        |            |
|                                                      | 1                                                                   | d been residing with the                                              |               |        |                                                                        |        |            |
|                                                      | ~                                                                   | ong time and could not                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     | the patient had moved.                                                |               |        |                                                                        |        |            |
|                                                      | The home health aide also indicated that the daughter was disabled. |                                                                       |               |        |                                                                        |        |            |
|                                                      | ine daughter was                                                    | s disabled.                                                           |               |        |                                                                        |        |            |
|                                                      | The 60 day sum                                                      | maries was repetitive                                                 |               |        |                                                                        |        |            |
|                                                      | _                                                                   | ion summary and failed                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     | d be reflective of the                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     | ring the 60 day period                                                |               |        |                                                                        |        |            |
|                                                      | 1 ^                                                                 | vard goals at the time of                                             |               |        |                                                                        |        |            |
|                                                      | the recertification                                                 | _                                                                     |               |        |                                                                        |        |            |
|                                                      | the recentification                                                 | 11.                                                                   |               |        |                                                                        |        |            |
|                                                      | 2. The clinical r                                                   | record for patient #3,                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     | was reviewed and                                                      |               |        |                                                                        |        |            |
|                                                      | included a plan                                                     |                                                                       |               |        |                                                                        |        |            |
|                                                      | _                                                                   | fod of 3/26/17 to 5/26/17                                             |               |        |                                                                        |        |            |
|                                                      |                                                                     | /27/17. The goals                                                     |               |        |                                                                        |        |            |
|                                                      |                                                                     | t will take medications as                                            |               |        |                                                                        |        |            |
|                                                      |                                                                     | B visual inspection of                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     | caregiver verbalize                                                   |               |        |                                                                        |        |            |
|                                                      |                                                                     | count is appropriate this                                             |               |        |                                                                        |        |            |
|                                                      |                                                                     | patient's safety will be                                              |               |        |                                                                        |        |            |
|                                                      | _                                                                   | shout the home care                                                   |               |        |                                                                        |        |            |
|                                                      |                                                                     | o falls / injuries or ER                                              |               |        |                                                                        |        |            |
|                                                      |                                                                     | t period. The patient's                                               |               |        |                                                                        |        |            |
|                                                      |                                                                     | s membranes will remain                                               |               |        |                                                                        |        |            |
|                                                      |                                                                     | ent's home environment                                                |               |        |                                                                        |        |            |
|                                                      |                                                                     |                                                                       |               |        |                                                                        |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 184 of 247

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION 00                                                                                                | (X3) DATE SURVEY COMPLETED 06/05/2017 |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------|
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 6525 E                              | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                      |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE                  |
|                          | will be clean and<br>personal care ne                                                                                                                                                                                                                                                                                                                                                                                                                                              | l safe, hygiene and eds will be met.                                                                                                                                                                                                                                                                                                                                                                                                                                |                                     |                                                                                                               |                                       |
|                          | certification peri included a 60 da "Client seen by lassessment for receipisode HHA seelderly male / fe an apartment with Rhabdomyolysis kidney and urete obesity. Client is weeks for medication and the with medication for personal care light housekeepirisk, unsteady gas walker at all time is incontinent of assistance with the Denied visits to certification perioriented but state and HOH [hard overbalized satisfied and services to be notified of receipt of care]. | s, diabetes, hypertension, or disorder, morbid s requiring SN every two ation setup, teaching to monitor compliance and efficacy and HHA e, meal prep / set up, and ng. Client is a high fall hit and ambulates with es, has poor endurance, furine and requires each incontinent episode. ER / hospitalizations this od. Client is alert and ed he / she is forgetful of hearing] Client faction with plan of care be provided. Physician tification and POC [plan |                                     |                                                                                                               |                                       |
|                          | B. The plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | of care for the                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                     |                                                                                                               |                                       |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 185 of 247

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

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                           |                                                          | ULTIPLE CO<br>UILDING | 00           | (X3) DATE<br>COMPL                                                 |          |                    |
|-----------------------------------------------|-------------------------------------------|----------------------------------------------------------|-----------------------|--------------|--------------------------------------------------------------------|----------|--------------------|
|                                               |                                           | 15K064                                                   | B. W                  | ING          |                                                                    | 06/05/   | 2017               |
| NAME OF F                                     | PROVIDER OR SUPPLIER                      |                                                          |                       | STREET A     | ADDRESS, CITY, STATE, ZIP CODE                                     | <u> </u> |                    |
|                                               |                                           |                                                          |                       |              | 82ND ST STE 216                                                    |          |                    |
|                                               | E HEALTH SERVIC                           |                                                          |                       | <u> </u>     | APOLIS, IN 46250                                                   |          |                    |
| (X4) ID<br>PREFIX                             |                                           | TATEMENT OF DEFICIENCIES                                 |                       | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |          | (X5)<br>COMPLETION |
| TAG                                           | •                                         | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |                       | TAG          | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | TE       | DATE               |
|                                               |                                           | od of 5/27/17 to 7/27/17,                                |                       | _            |                                                                    |          |                    |
|                                               | •                                         | y summary that indicated                                 |                       |              |                                                                    |          |                    |
|                                               |                                           | RN for comprehensive                                     |                       |              |                                                                    |          |                    |
|                                               |                                           | ecertification of services.                              |                       |              |                                                                    |          |                    |
|                                               | Client to be rece                         | rtified for another                                      |                       |              |                                                                    |          |                    |
|                                               | episode HHA se                            | rvices. Client is an                                     |                       |              |                                                                    |          |                    |
|                                               | elderly male / fe                         | male who lives alone in                                  |                       |              |                                                                    |          |                    |
|                                               | an apartment wit                          | th diagnosis of                                          |                       |              |                                                                    |          |                    |
|                                               | Rhabdomyolysis                            | s, diabetes, hypertension,                               |                       |              |                                                                    |          |                    |
|                                               | kidney and urete                          | er disorder, morbid                                      |                       |              |                                                                    |          |                    |
|                                               | obesity. Client is requiring SN every two |                                                          |                       |              |                                                                    |          |                    |
|                                               | weeks for medic                           | ation setup, teaching                                    |                       |              |                                                                    |          |                    |
|                                               |                                           | to monitor compliance                                    |                       |              |                                                                    |          |                    |
|                                               |                                           | and efficacy and HHA                                     |                       |              |                                                                    |          |                    |
|                                               | •                                         | e, meal prep / set up, light                             |                       |              |                                                                    |          |                    |
|                                               |                                           | Client is a high fall risk,                              |                       |              |                                                                    |          |                    |
|                                               |                                           | d ambulates with walker                                  |                       |              |                                                                    |          |                    |
|                                               |                                           | poor endurance, is                                       |                       |              |                                                                    |          |                    |
|                                               | incontinent of ur                         | _                                                        |                       |              |                                                                    |          |                    |
|                                               |                                           | each incontinent episode.                                |                       |              |                                                                    |          |                    |
|                                               |                                           | ER / hospitalizations this                               |                       |              |                                                                    |          |                    |
|                                               | •                                         | od. Client is alert and                                  |                       |              |                                                                    |          |                    |
|                                               |                                           | ed he / she is forgetful                                 |                       |              |                                                                    |          |                    |
|                                               | _                                         | of hearing] Client                                       |                       |              |                                                                    |          |                    |
|                                               |                                           | action with plan of care                                 |                       |              |                                                                    |          |                    |
|                                               |                                           | be provided. Physician                                   |                       |              |                                                                    |          |                    |
|                                               | notified of recer                         | tification and POC.                                      |                       |              |                                                                    |          |                    |
|                                               | The 60 day sum                            | maries was repetitive                                    |                       |              |                                                                    |          |                    |
|                                               | _                                         | ion summary and failed                                   |                       |              |                                                                    |          |                    |
|                                               |                                           | d be reflective of the                                   |                       |              |                                                                    |          |                    |
|                                               | _                                         | ring the 60 day period                                   |                       |              |                                                                    |          |                    |
|                                               | _                                         | vard goals at the time of                                |                       |              |                                                                    |          |                    |
|                                               | the recertificatio                        | _                                                        |                       |              |                                                                    |          |                    |
|                                               |                                           |                                                          |                       |              |                                                                    |          |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 186 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | CONSTRUCTION 00     | COMP                                                                                                       | E SURVEY<br>LETED<br>5/2017 |                            |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6525                | ET ADDRESS, CITY, STATE, ZIP CODI<br>I E 82ND ST STE 216<br>ANAPOLIS, IN 46250                             | <u>.</u>                    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | D BE                        | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            | SOC 11/21/16, vincluded a plan of certification period The goals indicated will be enhanced care services AE ER visits with consistency with a skin and mucous intact. The patient will be clean and personal care new A. The plan certification period 1/19/17, included that indicated "Comprehensive as recertification. Comprehensive as recertification. Comprehensive as the second distribution of the second distribution of the second distribution of the second distribution of the second distribution. It is a second distribution of the second distribution of the second distribution of the second distribution of the second distribution. The second distribution of the s | od of 5/20/17 to 7/18/17.  ted "The patient's safety I throughout the home B no falls / injuries or ert period. The patients is membranes will remain ent's home environment I safe, hygiene and eds will be met.  To f care for the od of 11/21/17 to d an admission summary client seen by RN for assessment 64 year old male / female A with dx of dementia. exterity and mentation. With medication ersonal care. Tires easily ertion. Is a fall risk and adder and bowel. Aide resonal care, light Patient lives in a group taff member to ent verbalized plan of care and services Physician notified of |                     |                                                                                                            |                             |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 187 of 247

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                       |                              | ULTIPLE CO<br>JILDING | NSTRUCTION | (X3) DATE<br>COMPL                                                  |        |            |
|-----------------------------------------------|---------------------------------------|------------------------------|-----------------------|------------|---------------------------------------------------------------------|--------|------------|
| ANDILAN                                       | OF CORRECTION                         | 15K064                       | B. W.                 |            | 00                                                                  | 06/05/ |            |
|                                               |                                       | 101(004                      |                       |            | DDDEGG CITY OT LTE ZID CODE                                         | 00/00/ | 72017      |
| NAME OF I                                     | PROVIDER OR SUPPLIEF                  | 8                            |                       |            | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                   |        |            |
| AT HOM                                        | E HEALTH SERVIC                       | CES LLC                      |                       |            | APOLIS, IN 46250                                                    |        |            |
| (X4) ID                                       | SUMMARY S                             | TATEMENT OF DEFICIENCIES     |                       | ID         | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                        |                                       | CY MUST BE PRECEDED BY FULL  |                       | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                           |                                       | LSC IDENTIFYING INFORMATION) |                       | TAG        | DEFICIENCY)                                                         |        | DATE       |
|                                               | •                                     | of care for the              |                       |            |                                                                     |        |            |
|                                               | _                                     | od of 1/20/17 to 3/20/17,    |                       |            |                                                                     |        |            |
|                                               | included an 60 day summary that       |                              |                       |            |                                                                     |        |            |
|                                               | indicated "Clien                      |                              |                       |            |                                                                     |        |            |
|                                               | comprehensive a                       |                              |                       |            |                                                                     |        |            |
|                                               |                                       | 64 year old male / female    |                       |            |                                                                     |        |            |
|                                               | admitted for HHA with dx of dementia. |                              |                       |            |                                                                     |        |            |
|                                               | Has decreased d                       | exterity and mentation.      |                       |            |                                                                     |        |            |
|                                               | Requires assist v                     | vith medication              |                       |            |                                                                     |        |            |
| reminders and personal care. Tires easily     |                                       |                              |                       |            |                                                                     |        |            |
| with minimal exertion. Is a fall risk and     |                                       |                              |                       |            |                                                                     |        |            |
| incontinent of bladder and bowel. Aide        |                                       |                              |                       |            |                                                                     |        |            |
|                                               | to assist with per                    | rsonal care, light           |                       |            |                                                                     |        |            |
|                                               | housekeeping. I                       | Patient lives in a group     |                       |            |                                                                     |        |            |
|                                               | home with one s                       | taff member to               |                       |            |                                                                     |        |            |
|                                               | supervisor Cli                        | ent verbalized               |                       |            |                                                                     |        |            |
|                                               | satisfaction with                     | plan of care and services    |                       |            |                                                                     |        |            |
|                                               | to be provided.                       | Physician notified of        |                       |            |                                                                     |        |            |
|                                               | recertification ar                    | nd POC.                      |                       |            |                                                                     |        |            |
|                                               |                                       |                              |                       |            |                                                                     |        |            |
|                                               | C. Review                             | of the clinical record, the  |                       |            |                                                                     |        |            |
|                                               | patient was hosp                      | italized in April for        |                       |            |                                                                     |        |            |
|                                               | possible seizure                      | activity AEB resumption      |                       |            |                                                                     |        |            |
|                                               | _                                     | ent dated 04/21/17.          |                       |            |                                                                     |        |            |
|                                               |                                       |                              |                       |            |                                                                     |        |            |
|                                               | D. The plan                           | of care for the              |                       |            |                                                                     |        |            |
|                                               | certification peri                    | od of 5/20/17 to 7/18/17,    |                       |            |                                                                     |        |            |
|                                               | _                                     | y summary that indicated     |                       |            |                                                                     |        |            |
|                                               |                                       | RN for comprehensive         |                       |            |                                                                     |        |            |
|                                               | _                                     | tification. 64 year old      |                       |            |                                                                     |        |            |
|                                               |                                       | mitted for HHA with dx       |                       |            |                                                                     |        |            |
|                                               |                                       | s decreased dexterity and    |                       |            |                                                                     |        |            |
|                                               | mentation. Requ                       |                              |                       |            |                                                                     |        |            |
|                                               | -                                     | nders and personal care.     |                       |            |                                                                     |        |            |
|                                               | l                                     | 1                            | 1                     |            |                                                                     |        | I          |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 188 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                      | ONSTRUCTION  OO                                                                     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                         |                      |  |  |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------|--|--|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                               |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |  |  |
|                                                                                                            | fall risk and incoloowel. Aide to a light housekeeping group home with supervisor [sic]? Client verbalized care and services. Physician notification poc."  E. An intervocational Services indicated that the home health aided due to the agence Prior Authorizat. The 60 day summarism the admission to be updated an patient status durand progress town the recertification.  4. The clinical roughly 1/30/17, was revolutionally 1/30/17, was revolutionally 1/30/17 to 5/29/10 nursing to provide times a week, unurostomy management. | view with the Director of s on 6/5/17 at 12:45 p.m., e patient did not start e services until 1/26/17 y waiting on Medicaid ion approval.  maries was repetitive ion summary and failed d be reflective of the ring the 60 day period ward goals at the time of |                                                                                     |                                                                                                               |                      |  |  |
|                                                                                                            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | due to disease process.                                                                                                                                                                                                                                         |                                                                                     |                                                                                                               |                      |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 189 of 247

| STATEMEN      | IT OF DEFICIENCIES                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA                                                                               | (X2) MULTIPLE CONSTRUCTION |               | NSTRUCTION                                                                            | (X3) DATE SURVEY                 |                    |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------|---------------|---------------------------------------------------------------------------------------|----------------------------------|--------------------|
| AND PLAN      | OF CORRECTION                                                                                                                                    | IDENTIFICATION NUMBER:                                                                                   | A. BU                      | JILDING       | 00                                                                                    | COMPL                            | ETED               |
|               |                                                                                                                                                  | 15K064                                                                                                   | B. W                       | ING           |                                                                                       | 06/05                            | /2017              |
| NAME OF B     | PROVIDER OR SUPPLIER                                                                                                                             |                                                                                                          | _                          | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                                        |                                  |                    |
| NAME OF P     | ROVIDER OR SUPPLIER                                                                                                                              |                                                                                                          |                            | 6525 E        | 82ND ST STE 216                                                                       |                                  |                    |
| AT HOME       | E HEALTH SERVIC                                                                                                                                  | CES LLC                                                                                                  |                            | INDIAN        | APOLIS, IN 46250                                                                      |                                  |                    |
| (X4) ID       |                                                                                                                                                  | TATEMENT OF DEFICIENCIES                                                                                 |                            | ID            | PROVIDER'S PLAN OF CORRECTION                                                         |                                  | (X5)<br>COMPLETION |
| PREFIX<br>TAG | `                                                                                                                                                | CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)                                               |                            | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | SS-REFERENCED TO THE APPROPRIATE |                    |
| TAU           |                                                                                                                                                  | alth aide] care is expected                                                                              |                            | TAG           | ,                                                                                     |                                  | DATE               |
|               |                                                                                                                                                  | due to disease process.                                                                                  |                            |               |                                                                                       |                                  |                    |
|               | The client's safety will be enhanced                                                                                                             |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               | throughout the home care services AEB                                                                                                            |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               | _                                                                                                                                                | s or ER visits within cert                                                                               |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | ent's skin and mucous                                                                                    |                            |               |                                                                                       |                                  |                    |
|               | •                                                                                                                                                | remain intact. The                                                                                       |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | vironment will be clean                                                                                  |                            |               |                                                                                       |                                  |                    |
|               | and safe, hygien                                                                                                                                 | e and personal care needs                                                                                |                            |               |                                                                                       |                                  |                    |
|               | will be met."                                                                                                                                    |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               | A. The plan                                                                                                                                      | n of care for the                                                                                        |                            |               |                                                                                       |                                  |                    |
|               | certification peri                                                                                                                               | iod of 1/30/17 to 3/30/17,                                                                               |                            |               |                                                                                       |                                  |                    |
|               | included an adm                                                                                                                                  | ission summary that                                                                                      |                            |               |                                                                                       |                                  |                    |
|               | indicated "53 ye                                                                                                                                 | ar old male / female                                                                                     |                            |               |                                                                                       |                                  |                    |
|               | admitted for SN                                                                                                                                  | [skilled nursing] and                                                                                    |                            |               |                                                                                       |                                  |                    |
|               | HHA [home hea                                                                                                                                    | alth aide] r/t [related to]                                                                              |                            |               |                                                                                       |                                  |                    |
|               | dx [diagnosis] o                                                                                                                                 | f Spina Bifada. Has                                                                                      |                            |               |                                                                                       |                                  |                    |
|               | decreased dexter                                                                                                                                 | rity and requires assist                                                                                 |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | me and ostomy care,                                                                                      |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | perform care for self,                                                                                   |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | , 0                                                                                                      |                            |               |                                                                                       |                                  |                    |
|               | housekeeping                                                                                                                                     | . "                                                                                                      |                            |               |                                                                                       |                                  |                    |
|               | D The plan                                                                                                                                       | a of agra for the                                                                                        |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               | •                                                                                                                                                | ·                                                                                                        |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | •                                                                                                        |                            |               |                                                                                       |                                  |                    |
|               | •                                                                                                                                                |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | •                                                                                                        |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               | =                                                                                                                                                |                                                                                                          |                            |               |                                                                                       |                                  |                    |
|               |                                                                                                                                                  | •                                                                                                        |                            |               |                                                                                       |                                  |                    |
|               | B. The plan certification per included an 60 d indicated "Clien comprehensive a recertification. damitted for SN HHA [home head dx [diagnosis] o | ersonal care, light . "  n of care for the find of 3/31/17 to 5/29/17, lay summary that t seen by RN for |                            |               |                                                                                       |                                  |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 190 of 247

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                     | r í                                                                                                                                                                             | JILDING | 00                  | (X3) DATE<br>COMPL<br>06/05/                                                                                           | ETED |                            |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------|------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
|                                                       | PROVIDER OR SUPPLIER                                                                                |                                                                                                                                                                                 |         | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                  |      |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                      | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                               |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE   | (X5)<br>COMPLETION<br>DATE |
|                                                       | patient unable to<br>dependent for pe<br>a slide board for<br>with minimal exc<br>incontinent of bo | ne and ostomy care, perform care for self, ersonal care. Patient uses transfers. Tires easily ertion. Is a high fall risk, owel and urostomy for ssist with personal care, ng " |         |                     |                                                                                                                        |      |                            |
|                                                       | from the admissi<br>to be updated and<br>patient status dur                                         | maries was repetitive from summary and failed do be reflective of the ring the 60 day period ward goals at the time of m.                                                       |         |                     |                                                                                                                        |      |                            |
|                                                       | Services and Em<br>Assistant Directo                                                                | the Director of Clinical aployee C, the Interim or of Clinical Services, in relation to the above 7 at 4:00 p.m.                                                                |         |                     |                                                                                                                        |      |                            |
|                                                       | further informati                                                                                   | the Alternate and Employee B, had no son or documentation by ace on 6/5/17 at 3:50 p.m.                                                                                         |         |                     |                                                                                                                        |      |                            |
| N 0533<br>Bldg. 00                                    | must be developed<br>the purpose of del<br>patient care provide<br>health agency for                | are A nursing plan of care d by a registered nurse for legating nursing directed ded through the home patients receiving only services in the absence of                        |         |                     |                                                                                                                        |      |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 191 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE C A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X3) DATE SURVEY COMPLETED 06/05/2017                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                     |  |  |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--|--|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                     |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X5) COMPLETION DATE                                |  |  |
|                                                                                                            | the following: (1) A plan of care identifying informa (2) The name of the control (3) Services to be (4) The frequency (5) Medications, (6) Signed and dispersonnel providing (7) Supervisory volume (8) Sixty (60) day (9) The discharge (10) The signature who developed the Based on record the agency failed health aide writth failed to coincid of care to include diagnosis (es), difficient to free visits, frequency and diagnoses in reviewed of patinaide only service (5, 7 and 8)  Findings included 1. The clinical resort (2) SOC (start of care for the diagnose of care for the | the patient's physician. It provided. If and duration of visits. Itiet, and activities. Itiet and all activities. Itiet and activiti | N 0533                                                                              | Director of Nursing/designee in-service nurses on ensuring home health aide plan of care specific, for each patient, regarding tasks aide to perfor frequency and duration of visi and frequency of tasks to be performed. (To be completed 8/25/17) Director of Nursing will be responsible to ensure orientat of newly hired nurses includes training on ensuring home heaide plan of care is specific, for each patient, regarding tasks to perform, frequency and duration of visits and frequency attacks to be performed. (To be by 8/25/17) Director of Nursing/designee and to monitor for compliance with making sure it specific regard tasks aide to perform, frequency and duration of visits and frequency of tasks to be | m, ts  by  ion s alth or aide cy of gin  will are n |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 192 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) M                       | (X3) DATE S             |                          |                                                                                        |         |            |
|------------------------------------------------------|----------------------|------------------------------|-------------------------|--------------------------|----------------------------------------------------------------------------------------|---------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:       |                         | JILDING                  | 00                                                                                     | COMPLI  |            |
|                                                      |                      | 15K064                       | B. W                    | ING                      |                                                                                        | 06/05/2 | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIER | <u> </u>                     |                         | STREET A                 | ADDRESS, CITY, STATE, ZIP CODE                                                         |         |            |
|                                                      |                      |                              |                         |                          | 82ND ST STE 216                                                                        |         |            |
| AT HOM                                               | E HEALTH SERVIC      | ES LLC                       |                         | INDIAN                   | APOLIS, IN 46250                                                                       |         |            |
| (X4) ID                                              |                      | TATEMENT OF DEFICIENCIES     |                         | ID                       | PROVIDER'S PLAN OF CORRECTION                                                          |         | (X5)       |
| PREFIX                                               | `                    | CY MUST BE PRECEDED BY FULL  |                         | PREFIX                   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE      | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION) |                         | TAG                      | performed. Once 100%                                                                   |         | DATE       |
|                                                      |                      | assist with personal         |                         |                          | compliance is achieved, 25%                                                            | of      |            |
|                                                      | 1 2                  | essing, activities of daily  |                         |                          | aide plans of care will be audit                                                       |         |            |
|                                                      |                      | o, medication reminders,     |                         |                          | monthly to monitor for                                                                 |         |            |
|                                                      | _                    | eeping. The nutrition        | compliance<br>8/25/17). | compliance. (To begin by |                                                                                        |         |            |
|                                                      |                      | ator 16) indicated the       |                         |                          | 8/25/17).<br>                                                                          |         |            |
|                                                      | -                    | mechanical soft diet and     |                         |                          |                                                                                        |         |            |
|                                                      | the patient was a    |                              |                         |                          |                                                                                        |         |            |
|                                                      |                      | tions (locator 18)           |                         |                          |                                                                                        |         |            |
|                                                      | _                    | ient was hearing and         |                         |                          |                                                                                        |         |            |
|                                                      |                      | . The mental status          |                         |                          |                                                                                        |         |            |
|                                                      | , ,                  | cated the patient was non    |                         |                          |                                                                                        |         |            |
|                                                      | - verbal. The par    | tient's diagnoses            |                         |                          |                                                                                        |         |            |
|                                                      | included, but not    | t limited to, Alzheimer's    |                         |                          |                                                                                        |         |            |
|                                                      | disease and demo     | entia with behavioral        |                         |                          |                                                                                        |         |            |
|                                                      | disturbances.        |                              |                         |                          |                                                                                        |         |            |
|                                                      |                      |                              |                         |                          |                                                                                        |         |            |
|                                                      | A. The hom           | ne health aide written       |                         |                          |                                                                                        |         |            |
|                                                      | patient instruction  | ons indicated the patient    |                         |                          |                                                                                        |         |            |
|                                                      | was an assist wit    | th feeding, bed,             |                         |                          |                                                                                        |         |            |
|                                                      | commode, elimii      | nation, mobility,            |                         |                          |                                                                                        |         |            |
|                                                      | transfers, and wh    | neelchair. The home          |                         |                          |                                                                                        |         |            |
|                                                      | health aide writte   | en patient instructions      |                         |                          |                                                                                        |         |            |
|                                                      | _                    | ient was on a regular        |                         |                          |                                                                                        |         |            |
|                                                      | diet. The home       | health aide written          |                         |                          |                                                                                        |         |            |
|                                                      | patient instruction  | ons included a complete      |                         |                          |                                                                                        |         |            |
|                                                      | bed bath, skin in    | spection, foot care, light   |                         |                          |                                                                                        |         |            |
|                                                      | housekeeping in      | the bathroom, kitchen,       |                         |                          |                                                                                        |         |            |
|                                                      | and bedroom, lin     | nen change, nail care,       |                         |                          |                                                                                        |         |            |
|                                                      | encourage fluids     | , hair care, meal prep,      |                         |                          |                                                                                        |         |            |
|                                                      |                      | nder, oral care, shampoo,    |                         |                          |                                                                                        |         |            |
|                                                      |                      | d placement / removal of     |                         |                          |                                                                                        |         |            |
|                                                      |                      | ace. The home health         |                         |                          |                                                                                        |         |            |
|                                                      | _                    | ructions failed to be        |                         |                          |                                                                                        |         |            |
|                                                      |                      | incide with the physician    |                         |                          |                                                                                        |         |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 193 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                            | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |          |                                                                                                    |        |            |
|-----------|------------------------------------------------------|------------------------------------------------------------|---------------------------------------------|----------|----------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:                                     | A. BU                                       | JILDING  | 00                                                                                                 | COMPL  | ETED       |
|           |                                                      | 15K064                                                     | B. W                                        | ING      |                                                                                                    | 06/05/ | 2017       |
|           |                                                      |                                                            |                                             | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                     |        |            |
| NAME OF F | PROVIDER OR SUPPLIEF                                 | C                                                          |                                             | 6525 E   | 82ND ST STE 216                                                                                    |        |            |
|           | E HEALTH SERVIC                                      |                                                            |                                             |          | APOLIS, IN 46250                                                                                   |        |            |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES                                   |                                             | ID       | PROVIDER'S PLAN OF CORRECTION                                                                      |        | (X5)       |
| PREFIX    | `                                                    | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) |                                             | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | ΓE     | COMPLETION |
| TAG       |                                                      | <u> </u>                                                   | 1                                           | TAG      | DEFICIENCE)                                                                                        |        | DATE       |
|           | 1 ^                                                  | e home health aide                                         |                                             |          |                                                                                                    |        |            |
|           |                                                      | ons failed to be specific                                  |                                             |          |                                                                                                    |        |            |
|           | and include frequency and duration of                |                                                            |                                             |          |                                                                                                    |        |            |
|           | visits, frequency of tasks to be                     |                                                            |                                             |          |                                                                                                    |        |            |
|           | performed.                                           |                                                            |                                             |          |                                                                                                    |        |            |
|           |                                                      |                                                            |                                             |          |                                                                                                    |        |            |
|           |                                                      | record for patient #5,                                     |                                             |          |                                                                                                    |        |            |
|           |                                                      | ncluded a plan of care for                                 |                                             |          |                                                                                                    |        |            |
|           |                                                      | period of 5/20/17 to                                       |                                             |          |                                                                                                    |        |            |
|           |                                                      | ders for home health aide                                  |                                             |          |                                                                                                    |        |            |
|           | services up to 6                                     | hours per day, 5 days per                                  |                                             |          |                                                                                                    |        |            |
|           | week to assist w                                     | ith personal care,                                         |                                             |          |                                                                                                    |        |            |
|           | bathing, dressing                                    | g, activities of daily                                     |                                             |          |                                                                                                    |        |            |
|           | living, meal prep                                    | o, medication reminders,                                   |                                             |          |                                                                                                    |        |            |
|           | and light housek                                     | eeping. The patient's                                      |                                             |          |                                                                                                    |        |            |
|           | diagnoses includ                                     | led, but not limited to,                                   |                                             |          |                                                                                                    |        |            |
|           | Tuberous scleros                                     | sis, dementia, weakness,                                   |                                             |          |                                                                                                    |        |            |
|           | and epilepsy / er                                    | pileptic syndrome with                                     |                                             |          |                                                                                                    |        |            |
|           | seizures.                                            |                                                            |                                             |          |                                                                                                    |        |            |
|           |                                                      |                                                            |                                             |          |                                                                                                    |        |            |
|           | A. The hom                                           | ne health aide written                                     |                                             |          |                                                                                                    |        |            |
|           | patient instruction                                  | ons included to assist the                                 |                                             |          |                                                                                                    |        |            |
|           | _                                                    | ower, skin inspection,                                     |                                             |          |                                                                                                    |        |            |
|           | 1 ^                                                  | r, light housekeeping in                                   |                                             |          |                                                                                                    |        |            |
|           | ·                                                    | tchen, and bedroom,                                        |                                             |          |                                                                                                    |        |            |
|           |                                                      | ot care, dressing,                                         |                                             |          |                                                                                                    |        |            |
|           |                                                      | , hair care, meal prep,                                    |                                             |          |                                                                                                    |        |            |
|           |                                                      | nder, oral care, shampoo,                                  |                                             |          |                                                                                                    |        |            |
|           |                                                      | s. The home health aide                                    |                                             |          |                                                                                                    |        |            |
|           |                                                      | ons failed to be specific                                  |                                             |          |                                                                                                    |        |            |
|           |                                                      | •                                                          |                                             |          |                                                                                                    |        |            |
|           | l -                                                  | uency and duration of                                      |                                             |          |                                                                                                    |        |            |
|           | visits, frequency                                    | of tasks to be                                             |                                             |          |                                                                                                    |        |            |
|           | performed.                                           |                                                            |                                             |          |                                                                                                    |        |            |
|           |                                                      |                                                            |                                             |          |                                                                                                    |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 194 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) M | JLTIPLE CO | NSTRUCTION                                                          | (X3) DATE | SURVEY     |
|-----------|------------------------------------------------------|------------------------------|--------|------------|---------------------------------------------------------------------|-----------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU  | ILDING     | 00                                                                  | COMPL     | ETED       |
|           |                                                      | 15K064                       | B. WI  | NG         |                                                                     | 06/05/    | 2017       |
|           |                                                      |                              |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                      |           |            |
| NAME OF P | ROVIDER OR SUPPLIER                                  | t .                          |        |            | 82ND ST STE 216                                                     |           |            |
| ΛΤ НОМΙ   | E HEALTH SERVIC                                      | ESTIC                        |        |            | APOLIS, IN 46250                                                    |           |            |
|           |                                                      |                              |        | INDIAN     | AI OLIO, IN 40230                                                   |           |            |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES     |        | ID         | PROVIDER'S PLAN OF CORRECTION                                       |           | (X5)       |
| PREFIX    | *                                                    | CY MUST BE PRECEDED BY FULL  |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ГЕ        | COMPLETION |
| TAG       |                                                      | LSC IDENTIFYING INFORMATION) |        | TAG        | DEFICIENCY)                                                         |           | DATE       |
|           |                                                      | ecord for patient #7,        |        |            |                                                                     |           |            |
|           | SOC 12/31/16, in                                     | ncluded a plan of care for   |        |            |                                                                     |           |            |
|           | the certification period of 4/9/17 to                |                              |        |            |                                                                     |           |            |
|           | 6/7/17, with orders for home health aide             |                              |        |            |                                                                     |           |            |
|           | services up to 6 hours per day, 7 days a             |                              |        |            |                                                                     |           |            |
|           | week. to assist with personal care,                  |                              |        |            |                                                                     |           |            |
|           | bathing, dressing, activities of daily               |                              |        |            |                                                                     |           |            |
|           |                                                      | o, medication reminders,     |        |            |                                                                     |           |            |
|           |                                                      | eeping per care plan.        |        |            |                                                                     |           |            |
|           | _                                                    | noses included, but not      |        |            |                                                                     |           |            |
|           | limited to, venou                                    |                              |        |            |                                                                     |           |            |
|           | · ·                                                  | • •                          |        |            |                                                                     |           |            |
|           | · ·                                                  | betes, and venous            |        |            |                                                                     |           |            |
|           | embolism.                                            |                              |        |            |                                                                     |           |            |
|           |                                                      |                              |        |            |                                                                     |           |            |
|           |                                                      | ne health aide written       |        |            |                                                                     |           |            |
|           | •                                                    | ons included to assist the   |        |            |                                                                     |           |            |
|           | patient with amb                                     | oulation, chair, dressing,   |        |            |                                                                     |           |            |
|           | bed, elimination,                                    | , mobility, bed bath, skin   |        |            |                                                                     |           |            |
|           | inspection, foot                                     | care, commode, transfers,    |        |            |                                                                     |           |            |
|           | walker, wheel ch                                     | nair, equipment care, hair   |        |            |                                                                     |           |            |
|           | care, meal prep.                                     | feeding, medication          |        |            |                                                                     |           |            |
|           |                                                      | are, positioning, peri care  |        |            |                                                                     |           |            |
|           | · ·                                                  | episode, shampoo, light      |        |            |                                                                     |           |            |
|           |                                                      | the bathroom, kitchen,       |        |            |                                                                     |           |            |
|           |                                                      |                              |        |            |                                                                     |           |            |
|           |                                                      | nen change, and wash         |        |            |                                                                     |           |            |
|           |                                                      | me health aide written       |        |            |                                                                     |           |            |
|           |                                                      | ed to be specific and        |        |            |                                                                     |           |            |
|           | -                                                    | ey and duration of visits,   |        |            |                                                                     |           |            |
|           |                                                      | ks to be performed. The      |        |            |                                                                     |           |            |
|           |                                                      | o be specific with           |        |            |                                                                     |           |            |
|           | indicating that th                                   | ne home health aide          |        |            |                                                                     |           |            |
|           | would not perfor                                     | rm trimming of nails due     |        |            |                                                                     |           |            |
|           | to the patient dia                                   | _                            |        |            |                                                                     |           |            |
|           | •                                                    |                              |        |            |                                                                     |           |            |

| STATEMEN      | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                             | (X2) M | ULTIPLE CO    | NSTRUCTION                                                         | (X3) DATE | SURVEY             |
|---------------|------------------------------------------------------|-------------------------------------------------------------|--------|---------------|--------------------------------------------------------------------|-----------|--------------------|
| AND PLAN      | OF CORRECTION                                        | IDENTIFICATION NUMBER:                                      | A. BU  | JILDING       | 00                                                                 | COMPL     | ETED               |
|               |                                                      | 15K064                                                      | B. W   | ING           |                                                                    | 06/05/    | /2017              |
|               |                                                      |                                                             |        | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                     |           |                    |
| NAME OF F     | ROVIDER OR SUPPLIER                                  | ₹                                                           |        |               | 82ND ST STE 216                                                    |           |                    |
| AT HOM        | E HEALTH SERVIC                                      | CESTIC                                                      |        |               | APOLIS, IN 46250                                                   |           |                    |
|               |                                                      |                                                             |        |               | 74 6216, 114 16266                                                 |           |                    |
| (X4) ID       |                                                      | TATEMENT OF DEFICIENCIES                                    |        | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |           | (X5)               |
| PREFIX<br>TAG | •                                                    | ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION) |        | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                      | TE        | COMPLETION<br>DATE |
| 1710          |                                                      | ,                                                           |        | 1710          | <u> </u>                                                           |           | DATE               |
|               |                                                      | record for patient #8,                                      |        |               |                                                                    |           |                    |
|               | -                                                    | luded a plan of care for                                    |        |               |                                                                    |           |                    |
|               | · ·                                                  | period of 3/3117 to                                         |        |               |                                                                    |           |                    |
|               | 5/29/17, with orders for home health aide            |                                                             |        |               |                                                                    |           |                    |
|               | services up to 8 hours per day, 7 days a             |                                                             |        |               |                                                                    |           |                    |
|               | week. to assist with personal care,                  |                                                             |        |               |                                                                    |           |                    |
|               |                                                      | g, activities of daily                                      |        |               |                                                                    |           |                    |
|               | living, meal prep                                    | o, medication reminders,                                    |        |               |                                                                    |           |                    |
|               | and light housek                                     | eeping per care plan.                                       |        |               |                                                                    |           |                    |
|               |                                                      |                                                             |        |               |                                                                    |           |                    |
|               | A. The hom                                           | ne health aide written                                      |        |               |                                                                    |           |                    |
|               | patient instruction                                  | ons included to assist the                                  |        |               |                                                                    |           |                    |
|               | -                                                    | , elimination, bed bath,                                    |        |               |                                                                    |           |                    |
|               | •                                                    | nail care, clean dentures,                                  |        |               |                                                                    |           |                    |
|               | •                                                    | t dressing, hair care, meal                                 |        |               |                                                                    |           |                    |
|               |                                                      | reminder, oral care,                                        |        |               |                                                                    |           |                    |
|               |                                                      | care after incontinent                                      |        |               |                                                                    |           |                    |
|               |                                                      |                                                             |        |               |                                                                    |           |                    |
|               |                                                      | busekeeping in the                                          |        |               |                                                                    |           |                    |
|               |                                                      | en, and bedroom, linen                                      |        |               |                                                                    |           |                    |
|               | U /                                                  | h clothes. The home                                         |        |               |                                                                    |           |                    |
|               |                                                      | en instructions failed to                                   |        |               |                                                                    |           |                    |
|               | _                                                    | nclude frequency and                                        |        |               |                                                                    |           |                    |
|               |                                                      | s, frequency of tasks to                                    |        |               |                                                                    |           |                    |
|               | be performed.                                        |                                                             |        |               |                                                                    |           |                    |
|               |                                                      |                                                             |        |               |                                                                    |           |                    |
|               | 5. Employee B.                                       | , the Director of Clinical                                  |        |               |                                                                    |           |                    |
|               | Services and Em                                      | ployee C, the Interim                                       |        |               |                                                                    |           |                    |
|               | Assistant Directo                                    | or of Clinical Services,                                    |        |               |                                                                    |           |                    |
|               | had no further in                                    | aformation or                                               |        |               |                                                                    |           |                    |
|               |                                                      | n relation to the above                                     |        |               |                                                                    |           |                    |
|               | findings on 6/2/1                                    |                                                             |        |               |                                                                    |           |                    |
|               | 1111011153 011 0/2/1                                 | т, ш т.оо р.ш.                                              |        |               |                                                                    |           |                    |
|               | 6 Employee A                                         | the Alternate                                               |        |               |                                                                    |           |                    |
|               | 6. Employee A,                                       |                                                             |        |               |                                                                    |           |                    |
|               | Aaministrator, ii                                    | ndicated at 12:00 p.m.,                                     |        |               |                                                                    |           | l                  |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUI                                                                                                                                                                                                                                                                                                                                 | LDING  | 00                  | (X3) DATE<br>COMPL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ETED       |                            |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------------------|
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15K064                                                                                                                                                                                                                                                                                                                                 | B. WIN | 1G                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 06/05/     | /2017                      |
|                                               | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                        |        | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |            |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                      | I      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                           | TE         | (X5)<br>COMPLETION<br>DATE |
| N 0537<br>Bldg. 00                            | information need aide care plan.  7. An undated p Health Aide / Ce (HHA ) Care in to the HHA the HHA, and to the being served Indocumentation the individualized to the services of Services Rule 1 Sec. 1(a) is shall provide nurse in accordance as follows:  Based on record the agency failed the plan of care in and duration of particular sample of 10.  Findings include 1. The clinical responsible in the certification in the side of the certification in the certification in the side of the side of the certification in the side of the side of the certification in the side of t | hat the client's care is his / her specific needs.  The home health agency ing services by a realicensed practical ce with the medical plan of review and interview, at to ensure staff followed in relation to frequency patient visits, personal ing services without a rein 3 of 4 active records ents with skilled nursing to (#3) | N 05   | 37                  | Director of Nursing will in-serv nurses on requirement to follor Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. visit is not made, nurse will document reason, complete a missed visit report and notify N of missed visit. (To be complete by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follor Plan of Care which includes frequency and duration for disciplines ordered by MD and | MD<br>eted | 08/25/2017                 |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 197 of 247

|           | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA                              |                              | (X2) MULTIPLE CONSTRUCTION (X3) DATE |                               |                                                                        |        |            |
|-----------|-----------------------------------------------------------------------------------|------------------------------|--------------------------------------|-------------------------------|------------------------------------------------------------------------|--------|------------|
| AND PLAN  | OF CORRECTION                                                                     | IDENTIFICATION NUMBER:       |                                      | JILDING                       | 00                                                                     | COMPL  |            |
|           |                                                                                   | 15K064                       | B. W                                 | ING                           |                                                                        | 06/05/ | /2017      |
| NAME OF I | PROVIDER OR SUPPLIEF                                                              | 3                            |                                      | STREET A                      | ADDRESS, CITY, STATE, ZIP CODE                                         |        |            |
|           |                                                                                   |                              |                                      |                               | 82ND ST STE 216                                                        |        |            |
| AT HOM    | E HEALTH SERVIC                                                                   | CES LLC                      |                                      | INDIAN                        | APOLIS, IN 46250                                                       |        |            |
| (X4) ID   | SUMMARY S                                                                         | TATEMENT OF DEFICIENCIES     |                                      | ID                            | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX    | `                                                                                 | ICY MUST BE PRECEDED BY FULL |                                      | PREFIX                        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ΓE     | COMPLETION |
| TAG       |                                                                                   | LSC IDENTIFYING INFORMATION) |                                      | TAG                           | DEFICIENCY)                                                            | 16     | DATE       |
|           |                                                                                   | or medication set up.        |                                      |                               | was tasks nurse is to provide. visit is not made, nurse will           | lf a   |            |
|           |                                                                                   | killed nursing visit notes   |                                      |                               | document reason, complete a                                            |        |            |
|           | in the electronic clinical record, the patient record contained a skilled nursing |                              |                                      |                               | missed visit report and notify N                                       | ИD     |            |
|           |                                                                                   |                              |                                      | of missed visit. (To begin by |                                                                        |        |            |
|           | visit note on 03/29/17, 4/21/17, 5/5/17,                                          |                              |                                      | 8/25/17)                      |                                                                        |        |            |
|           | 5/18/17, and 5/2                                                                  | 3/17. The clinical record    |                                      |                               | Director of Nursing/designee v audit 100% of nursing                   | VIII   |            |
|           | failed to evidence                                                                | ee a skilled nursing visit   |                                      |                               | documentation weekly, until                                            |        |            |
|           | between 04/09/1                                                                   | 7 to 4/15/17.                |                                      |                               | 100% compliance is achieved,                                           | to     |            |
|           |                                                                                   |                              |                                      |                               | monitor compliance with follow                                         | /ing   |            |
|           | 2. Employee B,                                                                    | the Director of Clinical     |                                      |                               | frequency and duration for                                             | الميد  |            |
|           | Services and Em                                                                   | ployee C, the Interim        |                                      |                               | disciplines ordered by MD as with MD ordered plan of care and t        |        |            |
|           | Alternate Direct                                                                  | or of Clinical Services,     |                                      |                               | care provided follows the MD                                           | ιιαι   |            |
|           | had no further in                                                                 | nformation or                |                                      |                               | ordered Plan of Care. Once 10                                          | 00%    |            |
|           | documentation i                                                                   | n relation to the above      |                                      |                               | compliance is achieved, Direct                                         | tor    |            |
|           | findings on 6/2/2                                                                 | 17 at 4:00 p.m.              |                                      |                               | of Nursing/designee will audit                                         |        |            |
|           |                                                                                   | •                            |                                      |                               | 25% of nursing documentation<br>monthly to monitor for continue        |        |            |
|           | 3. Employee A,                                                                    | the Alternate                |                                      |                               | compliance. (To begin 8/25/17                                          |        |            |
|           |                                                                                   | nd Employee B, had no        |                                      |                               |                                                                        |        |            |
|           |                                                                                   | ion or documentation by      |                                      |                               |                                                                        |        |            |
|           |                                                                                   | nce on 6/5/17 at 3:50 p.m.   |                                      |                               |                                                                        |        |            |
|           |                                                                                   | on over 17 we sie o piin.    |                                      |                               |                                                                        |        |            |
|           | 4. An undated p                                                                   | oolicy titled "Plan of       |                                      |                               |                                                                        |        |            |
|           | _                                                                                 | ndicated " Planning for      |                                      |                               |                                                                        |        |            |
|           | · ·                                                                               | c process that addresses     |                                      |                               |                                                                        |        |            |
|           | _                                                                                 | ent and services to be       |                                      |                               |                                                                        |        |            |
|           | · ·                                                                               | individualized Plan of       |                                      |                               |                                                                        |        |            |
|           | -                                                                                 | a comprehensive              |                                      |                               |                                                                        |        |            |
|           |                                                                                   | information provided by      |                                      |                               |                                                                        |        |            |
|           |                                                                                   | y and health team            |                                      |                               |                                                                        |        |            |
|           |                                                                                   | Plan of Care shall be        |                                      |                               |                                                                        |        |            |
|           |                                                                                   | l to include Type,           |                                      |                               |                                                                        |        |            |
|           | -                                                                                 | luration of all visits /     |                                      |                               |                                                                        |        |            |
|           |                                                                                   | ations, treatments, and      |                                      |                               |                                                                        |        |            |
|           | procedures "                                                                      | mons, ireannents, and        |                                      |                               |                                                                        |        |            |
|           | procedures                                                                        |                              |                                      |                               |                                                                        |        |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                            |                                                                                           |        | (X3) DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DATE SURVEY                            |            |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------|
| AND PLAN                                           | AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                       | A. BU                                                                                     | ILDING | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | COMPL                                  | ETED       |
|                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 15K064                                                                                                                                                                                                | B. WI                                                                                     | NG     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 06/05/                                 | 2017       |
|                                                    | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                        |            |
| (X4) ID                                            | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES                                                                                                                                                                              |                                                                                           | ID     | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                        | (X5)       |
| PREFIX                                             | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CY MUST BE PRECEDED BY FULL                                                                                                                                                                           |                                                                                           | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TE                                     | COMPLETION |
| TAG                                                | REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | LSC IDENTIFYING INFORMATION)                                                                                                                                                                          |                                                                                           | TAG    | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                        | DATE       |
| N 0541<br>Bldg. 00                                 | services are limite purposes of practi setting, the register following: (B) Regularly reevolution nursing needs. Based on record the agency failed Registered Nurse following surger                                                                                                                                                                                                                                                                                                                                                                              | (1)(B) Except where d to therapy only, for ce in the home health ered nurse shall do the valuate the patient's review and interview, I to ensure that a e reassessed a patient y in 1 out of 1 record | N 0:                                                                                      | 541    | Director of Nursing/designee winstruct staff on proofing documentation before submittito ensure dates are correct. (Tibe done 8/25/17) Director of Nursing will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ng                                     | 08/25/2017 |
|                                                    | following surgery in 1 out of 1 record reviewed of a patient who received surgical procedure during a certification period in a sample of 10. (#6)  Findings include:  1. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 3 times a week.  A. A Communication log dated 3/30/17, indicated the patient declined home health aide visit on 7/6/17 (verified by Director of Clinical Services as a typo and should read 4/6/17) due to having surgery. |                                                                                                                                                                                                       |                                                                                           |        | responsible to ensure orientation of newly hired staff are instruction proofing documentation bethe submitting to ensure dates are correct. (To begin 8/25/17) Director of Nursing/designee waudit 100% of documentation weekly to ensure the dates on documentation are correct. On 100% compliance is achieved, Director of Nursing/designee waudit 25% of documentation monthly to monitor for compliance. (To begin by 8/25/17). Director of Nursing/designee win-service RN's on need to assess patient, before any oth discipline makes visit, when the have had a hospital stay or a surgical procedure done to see plan of care needs to be adjus (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired RN's includes | ted fore vill nce vill er ey e if ted. |            |
|                                                    | 4/7/17, indicated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | rsing visit note dated la LPN (Licensed conducted a visit, which                                                                                                                                      |                                                                                           |        | Director of Nursing will be responsible to ensure orientati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | on                                     |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 199 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV |          |                                                                                        | SURVEY |            |
|-----------|------------------------------------------------------|------------------------------|-------------------------------------------|----------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:       |                                           | JILDING  | 00                                                                                     | COMPL  | ETED       |
|           |                                                      | 15K064                       | B. W                                      | ING      |                                                                                        | 06/05/ | 2017       |
| NAME OF I | PROVIDER OR SUPPLIER                                 |                              | •                                         | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                         |        |            |
| NAME OF I | ROVIDER OR SUFFLIER                                  |                              |                                           | 6525 E   | 82ND ST STE 216                                                                        |        |            |
|           | E HEALTH SERVIC                                      | CES LLC                      |                                           | INDIAN   | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES     |                                           | ID       | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)       |
| PREFIX    | `                                                    | ICY MUST BE PRECEDED BY FULL |                                           | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE     | COMPLETION |
| TAG       |                                                      | LSC IDENTIFYING INFORMATION) |                                           | TAG      | · ·                                                                                    |        | DATE       |
|           |                                                      | the surgical procedure       |                                           |          | patient, before any other discipline makes visit, when the                             | ΑV     |            |
|           |                                                      | on 4/6/17. Employee C,       |                                           |          | have had a hospital stay or a                                                          | Су     |            |
|           |                                                      | stant Director of Clinical   |                                           |          | surgical procedure done to see                                                         | e if   |            |
|           | Services made a                                      | supervisory visit on         |                                           |          | plan of care needs to be adjusted.                                                     |        |            |
|           | 4/21/17, but faile                                   | ed to assess the patient.    |                                           |          | (To begin by 8/25/17)                                                                  |        |            |
|           |                                                      |                              |                                           |          | Director of Nursing/designee v                                                         |        |            |
|           | B. A Comn                                            | nunication log dated         |                                           |          | audit 100% of documentation to patients who have had a hospi                           |        |            |
|           | 5/3/17, indicated                                    | I the patient declined a     |                                           |          | stay or a surgical procedure do                                                        |        |            |
|           | · · · · · · · · · · · · · · · · · · ·                | e visit on 5/4/17, due to    |                                           |          | to monitor for compliance with                                                         |        |            |
|           | having surgery.                                      | ,                            |                                           |          | documentation they have beer                                                           |        |            |
|           | naving surgery.                                      |                              |                                           |          | assessed by an RN before any                                                           | /      |            |
|           | 1 Δ nii                                              | rsing visit note dated       |                                           |          | other disciplines provide care.                                                        |        |            |
|           |                                                      | d a LPN conducted a          |                                           |          | Once 100% compliance is achieved 25% of documentation                                  | n      |            |
|           | · · · · · · · · · · · · · · · · · · ·                |                              |                                           |          | will be audited monthly for thos                                                       |        |            |
|           |                                                      | ed to evidence the           |                                           |          | patients to ensure compliance                                                          |        |            |
|           | ,                                                    | are the patient had on       |                                           |          | (To begin by 8/25/17)                                                                  |        |            |
|           |                                                      | ee C made a supervisory      |                                           |          | Director of Nursing will be                                                            |        |            |
|           | 1                                                    | but failed to assess the     |                                           |          | responsible for monitoring thes                                                        |        |            |
|           | patient.                                             |                              |                                           |          | corrective actions to ensure th<br>deficiency is corrected and will                    |        |            |
|           | C Th                                                 | Desistant I Norma            |                                           |          | not recur.08/25/2017                                                                   |        |            |
|           |                                                      | Registered Nurse             |                                           |          |                                                                                        |        |            |
|           |                                                      | ssessment visit was          |                                           |          |                                                                                        |        |            |
|           |                                                      | 29/17, by Employee C.        |                                           |          |                                                                                        |        |            |
|           | 1 2                                                  | ed to conduct the initial    |                                           |          |                                                                                        |        |            |
|           | visit and reasses                                    | s the patient after the      |                                           |          |                                                                                        |        |            |
|           | patient had surge                                    | ery.                         |                                           |          |                                                                                        |        |            |
|           |                                                      |                              |                                           |          |                                                                                        |        |            |
|           | 1 -                                                  | ee C was unable to           |                                           |          |                                                                                        |        |            |
|           |                                                      | her documentation when       |                                           |          |                                                                                        |        |            |
|           | asked on 6/5/17                                      | at 1.30 p.m.                 |                                           |          |                                                                                        |        |            |
|           | 2 An undated n                                       | oolicy titled "Skilled       |                                           |          |                                                                                        |        |            |
|           | _                                                    | s" C - 200, indicated "      |                                           |          |                                                                                        |        |            |
|           |                                                      | Nurse Regularly              |                                           |          |                                                                                        |        |            |
|           | _                                                    | • •                          |                                           |          |                                                                                        |        |            |
|           | reevaluates the c                                    | elients needs, and           |                                           |          |                                                                                        |        |            |

| STATEMENT OF DEFICIENCIES X1) PROV |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION                                                          |        | ONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X3) DATE SURVEY                              |            |
|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------|
| AND PLAN                           | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                               | A. BU                                                                               | ILDING | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | COMPL                                         | ETED       |
|                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 15K064                                                                                                                                                                                                                                                                                               | B. WI                                                                               | NG     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 06/05/                                        | 2017       |
|                                    | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                               |            |
| (X4) ID                            | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                             |                                                                                     | ID     | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X5)                                          |            |
| PREFIX                             | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                          |                                                                                     | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TE                                            | COMPLETION |
| TAG                                | REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                         |                                                                                     | TAG    | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                               | DATE       |
|                                    | coordinates the r                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | necessary services "                                                                                                                                                                                                                                                                                 |                                                                                     |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                               |            |
| N 0542<br>Bldg. 00                 | 410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a) services are limite purposes of practices setting, the register following:  (C) Initiate the plane revisions.  Based on record the agency failed care was updated determination of aide visits specific patient's needs in records reviewed patients with hor sample of 10; fair parameters for shoxygen saturation records reviewed in a sample of 10 patient's personal be provided on the home visits condupdate a medical active records reto include g-tube and frequency of amount, and frequency of amount, and frequency of and instruction of vent and bypap in rescue in 1 of 1 medical services. | (1)(C) Except where d to therapy only, for ce in the home health ered nurse shall do the an of care and necessary review and interview, I to ensure the plan of the include the duration of home health ic and pertinent to the a 6 out of 7 active I (#2, 3, 4, 5, 7 and 8) of me health aides in a | N 0:                                                                                | 542    | Director of Nursing/designee vinstruct nurses when patient horder for home health aide to indicate who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurse should indicate if patient is cognitive to make own personate decisions. If not then indicate who determines time caregiver, RN, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instructing nurses when patienthas order for home health aide indicate who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurse should indicate if patient is cognitive to make own personate decisions. If not then indicate who determines time caregiver, RN, etc. (To begin to 8/25/17) Director of Nursing/designee valudit, weekly, 100% of Plans of Care to monitor for compliance | as s es al - ion s te to s es al - by will of | 08/25/2017 |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 201 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                | (X2) MULTIPLE CONSTRUCTION |          |                                                                                       | (X3) DATE SURVEY |   |
|-----------|------------------------------------------------------|--------------------------------|----------------------------|----------|---------------------------------------------------------------------------------------|------------------|---|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:         | A. BU                      | JILDING  | 00                                                                                    | COMPLETED        |   |
|           |                                                      | 15K064                         | B. Wl                      | ING      |                                                                                       | 06/05/2017       |   |
| NAME OF I | DROVIDED OD CUDDI IEI                                |                                |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                        |                  |   |
| NAME OF F | PROVIDER OR SUPPLIE                                  | K                              |                            | 6525 E   | 82ND ST STE 216                                                                       |                  |   |
| AT HOM    | E HEALTH SERVIC                                      | CES LLC                        |                            | INDIAN   | APOLIS, IN 46250                                                                      |                  |   |
| (X4) ID   |                                                      | STATEMENT OF DEFICIENCIES      |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                                         | (X:              |   |
| PREFIX    |                                                      | NCY MUST BE PRECEDED BY FULL   |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                  |   |
| TAG       |                                                      | R LSC IDENTIFYING INFORMATION) |                            | TAG      | ·                                                                                     | DAT              | E |
|           | machine (#4); and failed to include other            |                                |                            |          | with indicating who is respons to determine how many hours                            | bie              |   |
|           | entities / agencies assisting with the               |                                |                            |          | patient needs when order says                                                         | ;                |   |
|           | patients care in 2 out of 4 active records           |                                |                            |          | "up to" number of hours. Nurse                                                        |                  |   |
|           | of patients with                                     | more than one service in       |                            |          | should indicate if patient is                                                         |                  |   |
|           | a sample of 10.                                      | (# 6 and 7)                    |                            |          | cognitive to make own person                                                          | al               |   |
|           |                                                      |                                |                            |          | care decisions. If not then indicate who determines time                              |                  |   |
|           | Findings include                                     | e:                             |                            |          | caregiver, RN, etc. Once 100%                                                         |                  |   |
|           |                                                      |                                |                            |          | compliance is achieved, Direc                                                         |                  |   |
|           | 1. The clinical i                                    | record for patient #2,         |                            |          | of Nursing/designee will audit                                                        |                  |   |
|           | SOC (start of ca                                     | re) 3/6/12, included a         |                            |          | 25% of Plans of Care monthly                                                          |                  |   |
|           | ·                                                    | the certification period of    |                            |          | monitor for compliance. (To be                                                        | gin              |   |
|           | 4/9/17 to 6/7/17                                     | •                              |                            |          | by 8/25/17) Director of Nursing/designee v                                            | rill             |   |
|           | , 17 60 077717                                       | •                              |                            |          | instruct nurses to indicate on F                                                      |                  |   |
|           | A The plan                                           | n of care indicated home       |                            |          | of Care the following: the corre                                                      |                  |   |
|           | _                                                    | to 8 hours per day, 5          |                            |          | address, status of others living                                                      |                  |   |
|           | -                                                    | The durations of hours         |                            |          | the home, what tasks are to be                                                        | •                |   |
|           |                                                      | ent specific and include       |                            |          | provided by staff and when(nursing/aide). (To be                                      |                  |   |
|           | 1                                                    | •                              |                            |          | completed by 8/25/17)                                                                 |                  |   |
|           |                                                      | irs per day for the home       |                            |          | Director of Nursing will be                                                           |                  |   |
|           |                                                      | e in the home and who          |                            |          | responsible to ensure newly h                                                         |                  |   |
|           |                                                      | ed the duration of hours       |                            |          | nurses are trained to indicate                                                        | on               |   |
|           |                                                      | the home health aide not       |                            |          | Plan of Care the following: the correct address, status of other                      | re               |   |
|           | be needed for th                                     | e entire 8 hours.              |                            |          | living in the home, what tasks                                                        |                  |   |
|           |                                                      |                                |                            |          | to be provided by staff and                                                           |                  |   |
|           | _                                                    | of care indicated skilled      |                            |          | when(nursing/aide). (To be be                                                         | gin              |   |
|           | _                                                    | n oxygen saturations as        |                            |          | by 8/25/17)                                                                           |                  |   |
|           | needed. The pla                                      | nn of care failed to           |                            |          | Director of Nursing/designee v                                                        |                  |   |
|           | indicate when to                                     | o obtain oxygen                |                            |          | audit, weekly, 100% of Plans of Care to monitor for compliance                        |                  |   |
|           | saturations.                                         |                                |                            |          | indicating the Plan of Care has                                                       |                  |   |
|           |                                                      |                                |                            |          | the following: the correct addre                                                      |                  |   |
|           | C. A home                                            | visit on 6/1/17 at 9:15        |                            |          | status of others living in the                                                        |                  |   |
|           | a.m., was conducted at the patient's                 |                                |                            |          | home, what tasks are to be                                                            |                  |   |
|           |                                                      | where the patient had          |                            |          | provided by staff and when(nursing/aide). Once 100                                    | <sub>%</sub>     |   |
|           |                                                      | The new address of             |                            |          | compliance is achieved, Direc                                                         |                  |   |
|           | _                                                    | ot listed on the plan of       |                            |          | of Nursing/designee will audit                                                        |                  |   |
|           |                                                      | 1                              | 1                          |          |                                                                                       | 1                |   |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 202 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                         | (X2) MULTIPLE CONSTRUCTION |          |                                                                     | (X3) DATE SURVEY |            |
|-----------|------------------------------------------------------|-----------------------------------------|----------------------------|----------|---------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:                  | A. BU                      | JILDING  | 00                                                                  | COMPL            | ETED       |
|           |                                                      | 15K064                                  | B. W                       | ING      |                                                                     | 06/05/           | 2017       |
|           |                                                      |                                         |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                      | <u> </u>         |            |
| NAME OF I | PROVIDER OR SUPPLIEF                                 | 8                                       |                            |          | 82ND ST STE 216                                                     |                  |            |
| AT HOM    | E HEALTH SERVIC                                      | CES LLC                                 |                            |          | IAPOLIS, IN 46250                                                   |                  |            |
| (X4) ID   | SUMMARY S                                            | TATEMENT OF DEFICIENCIES                |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                       |                  | (X5)       |
| PREFIX    | · ·                                                  | ICY MUST BE PRECEDED BY FULL            |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG       |                                                      | LSC IDENTIFYING INFORMATION)            |                            | TAG      | DEFICIENCY)                                                         |                  | DATE       |
|           | •                                                    | of care included a former               |                            |          | 25% of Plans of Care monthly monitor for compliance. (To be         |                  |            |
|           | address where so                                     | ervices were initially                  |                            |          | by 8/25/17)                                                         | egiii            |            |
|           | provided. Duri                                       | ng this time, the home                  |                            |          | Director of Nursing/designee v                                      | will             |            |
|           | health aide indic                                    | ated the patient use to                 |                            |          | instruct nurses that a verbal o                                     |                  |            |
|           | live with the son                                    | but moved in with the                   |                            |          | is needed from MD to make e                                         | xtra             |            |
|           | daughter and had                                     | d been residing with the                |                            |          | visits that fall outside the orde                                   |                  |            |
|           | _                                                    | ong time and could not                  |                            |          | visit frequency for that discipling                                 |                  |            |
|           | _                                                    | the patient had moved.                  |                            |          | of the Plan of Care and the nu must complete documentation          |                  |            |
|           |                                                      | a aide also indicated that              |                            |          | all visits made. (To be comple                                      |                  |            |
|           |                                                      |                                         |                            |          | by 8/25/17)                                                         |                  |            |
|           | the daughter was disabled.                           |                                         |                            |          | Director of Nursing will be                                         |                  |            |
|           |                                                      |                                         |                            |          | responsible to ensure orientat                                      | ion              |            |
|           |                                                      | record for patient #3,                  |                            |          | of newly hired nurses includes                                      |                  |            |
|           | SOC 11/28/16, i                                      | ncluded a plan of care                  |                            |          | training on needing a verbal o                                      |                  |            |
|           | with orders for s                                    | killed nursing every 14                 |                            |          | from MD to make extra visits t                                      | inat             |            |
|           | days for medicat                                     | tion set up, oxygen                     |                            |          | fall outside the ordered visit<br>frequency for that discipline of  | f the            |            |
|           | saturations as ne                                    | eded and home health                    |                            |          | Plan of Care and nurse must                                         | i tiiC           |            |
|           | aide services up                                     | to 8 hours per day, 7                   |                            |          | complete documentation for a                                        | II               |            |
|           | days a week.                                         | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |                            |          | visits made. (To begin by 8/25                                      |                  |            |
|           | days a week.                                         |                                         |                            |          | Director of Nursing/designee v                                      |                  |            |
|           | A On 5/21                                            | /17 at 2:00 n m                         |                            |          | track all nursing visits for a mo                                   |                  |            |
|           |                                                      | /17 at 3:00 p.m.,                       |                            |          | to monitor for compliance with                                      | 1                |            |
|           |                                                      | Interim Assistant                       |                            |          | following ordered frequency and if extra visits ar                  | ΄                |            |
|           |                                                      | ical Services, indicated                |                            |          | noted there is a verbal order for                                   |                  |            |
|           |                                                      | extra visits to the                     |                            |          | that visit and that nurse has                                       | •                |            |
|           | *                                                    | of ix the medication box                |                            |          | completed documentation for                                         |                  |            |
|           | due to medication                                    | ons not being refilled                  |                            |          | visits. Once 100% compliance                                        |                  |            |
|           | before her visit.                                    |                                         |                            |          | achieved, Director of Nursing track 25% of patients monthly         |                  |            |
|           | D On 5/21                                            | /17 at 4:10 n m                         |                            |          | monitor for compliance. (To be                                      | egin             |            |
|           |                                                      | /17 at 4:10 p.m.,                       |                            |          | by 8/25/17)                                                         |                  |            |
|           |                                                      | icated she was going to                 |                            |          | Director of Nursing will instruct nurses on including reason for    |                  |            |
|           | _                                                    | 's home that evening and                |                            |          | doing pulse oximetry, if there                                      |                  |            |
|           | _                                                    | atient had his / her                    |                            |          | an order on Plan of Care to do                                      |                  |            |
|           | medication for o                                     | our home visit on 6/1/17.               |                            |          | one. (To be done by 8/25/17)                                        |                  |            |
|           |                                                      |                                         |                            |          | Director of Nursing will be                                         |                  |            |
|           | C. On 6/2/1                                          | 7 at 4:45 p.m., Employee                |                            |          | responsible to ensure orientat                                      | ion              |            |

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION |          |                                                                                        | (X3) DATE SURVEY |            |
|-----------|------------------------------------------------------|------------------------------|----------------------------|----------|----------------------------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU                      | JILDING  | 00                                                                                     | COMPL            | ETED       |
|           |                                                      | 15K064                       | B. WI                      | ING      |                                                                                        | 06/05/           | 2017       |
|           |                                                      |                              |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                         |                  |            |
| NAME OF F | PROVIDER OR SUPPLIER                                 | t                            |                            |          | 82ND ST STE 216                                                                        |                  |            |
| ΔТ НΩМІ   | E HEALTH SERVIC                                      | ESUC                         |                            |          | APOLIS, IN 46250                                                                       |                  |            |
|           |                                                      |                              |                            |          | Al OLIO, IIV 40230                                                                     |                  |            |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES     |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                                          |                  | (X5)       |
| PREFIX    | ,                                                    | CY MUST BE PRECEDED BY FULL  |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE               | COMPLETION |
| TAG       |                                                      | LSC IDENTIFYING INFORMATION) |                            | TAG      | ·                                                                                      |                  | DATE       |
|           |                                                      | did not obtain orders nor    |                            |          | of newly hired nurses includes<br>training on including reason fo                      |                  |            |
|           | did she complete                                     | e nursing visit notes.       |                            |          | doing pulse oximetry, if there i                                                       |                  |            |
|           |                                                      |                              |                            |          | an order on Plan of Care to do                                                         |                  |            |
|           | D. Review                                            | of the home health aide      |                            |          | one. (To begin by 8/25/17)                                                             |                  |            |
|           | visit notes dated                                    | 03/29, 4/4, 4/9, 4/21,       |                            |          | Director of Nursing will in-serv                                                       | ice              |            |
|           |                                                      | 118, and 5/23/17, the        |                            |          | nurses on coordinating care w                                                          |                  |            |
|           |                                                      | e provided services          |                            |          | all medical agencies involved                                                          | with             |            |
|           |                                                      | rom 3 hours to 7 hours.      |                            |          | patient. Training will include                                                         |                  |            |
|           | approximately II                                     | om 5 hours to 7 hours.       |                            |          | documenting name of agency,<br>name/title of person spoke with                         |                  |            |
|           | The plan of some                                     | failed to be undeted to      |                            |          | payer, discipline(s), frequency                                                        |                  |            |
|           | •                                                    | failed to be updated to      |                            |          | duration and tasks to be provide                                                       |                  |            |
|           |                                                      | its for skilled nursing in   |                            |          | (To be done by 8/25/17)                                                                |                  |            |
|           | the management                                       | •                            |                            |          | Director of Nursing will be                                                            |                  |            |
|           | medications in b                                     | etween scheduled visits,     |                            |          | responsible to ensure orientati                                                        |                  |            |
|           | duration of home                                     | e health aide hours failed   |                            |          | of newly hired nurses includes                                                         |                  |            |
|           | to be patient spe                                    | cific to include the         |                            |          | training on coordinating care wall medical agencies involved                           |                  |            |
|           | minimal hours p                                      | er day for the home          |                            |          | patient. Training will include                                                         | WILLI            |            |
|           | _                                                    | in the home as well as       |                            |          | documenting name of agency,                                                            |                  |            |
|           |                                                      | rmined the duration of       |                            |          | name/title of person spoke wit                                                         | h,               |            |
|           |                                                      | nould the home health        |                            |          | payer, discipline(s), frequency                                                        | ,                |            |
|           |                                                      | ed for the entire 8 hours    |                            |          | duration and tasks to be                                                               | _`               |            |
|           |                                                      |                              |                            |          | provided. (To begin by 8/25/1                                                          |                  |            |
|           | and when to obta                                     | ain oxygen saturations.      |                            |          | Director of Nursing/designee v audit 100% of admissions,                               | VIII             |            |
|           |                                                      |                              |                            |          | resumptions and re-certification                                                       | ns               |            |
|           |                                                      | ecord for patient #4,        |                            |          | to monitor for compliance of                                                           | -                |            |
|           | · · · · · · · · · · · · · · · · · · ·                | cluded a plan of care for    |                            |          | coordinating care with other                                                           |                  |            |
|           | the certification                                    | period of 4/24/17 to         |                            |          | medical agencies, if there are                                                         |                  |            |
|           | 6/22/17, with ord                                    | ders for a LPN (licensed     |                            |          | any. (To begin by 8/25/17)                                                             |                  |            |
|           | practical nurse)                                     | up to 3 hours per day, 5     |                            |          | Director of Nursing is responsi                                                        |                  |            |
|           |                                                      | ssist with personal care,    |                            |          | for monitoring these corrective<br>actions to ensure that this                         |                  |            |
|           | _                                                    | ation reminders, meal        |                            |          | deficiency is corrected and wil                                                        |                  |            |
|           | preparation / set                                    | •                            |                            |          | not recur.                                                                             |                  |            |
|           |                                                      | The plan of care also        |                            |          |                                                                                        |                  |            |
|           |                                                      | -                            |                            |          |                                                                                        |                  |            |
|           |                                                      | skilled nurse to obtain      |                            |          |                                                                                        |                  |            |
|           | oxygen saturatio                                     | ns as needed.                |                            |          |                                                                                        |                  |            |
|           |                                                      |                              |                            |          |                                                                                        |                  |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 204 of 247

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |                              | ULTIPLE CO<br>UILDING | NSTRUCTION 00 | (X3) DATE<br>COMPL                                                                    |        |            |
|-----------------------------------------------|----------------------|------------------------------|-----------------------|---------------|---------------------------------------------------------------------------------------|--------|------------|
| ANDIEM                                        | or conduction        | 15K064                       | B. W                  |               | 00                                                                                    | 06/05/ |            |
|                                               |                      | 101001                       |                       | CTREET        | DDDEGG CITY CTATE 7ID CODE                                                            | 00/00/ | 2011       |
| NAME OF F                                     | PROVIDER OR SUPPLIER | ₹                            |                       | 1             | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                     |        |            |
| AT HOM                                        | E HEALTH SERVIC      | CES LLC                      |                       | 1             | APOLIS, IN 46250                                                                      |        |            |
| (X4) ID                                       | SUMMARY S            | TATEMENT OF DEFICIENCIES     |                       | ID            | PROVIDER'S PLAN OF CORRECTION                                                         |        | (X5)       |
| PREFIX                                        |                      | CY MUST BE PRECEDED BY FULL  |                       | PREFIX        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                           |                      | LSC IDENTIFYING INFORMATION) |                       | TAG           | DEFICIENCY)                                                                           |        | DATE       |
|                                               | _                    | home visit on 6/1/17 at      |                       |               |                                                                                       |        |            |
|                                               | _                    | Employee E, a LPN, was       |                       |               |                                                                                       |        |            |
|                                               |                      | inister liquid dilantin      |                       |               |                                                                                       |        |            |
|                                               | `                    | dication), tylenol and       |                       |               |                                                                                       |        |            |
|                                               |                      | for mild pain and / or       |                       |               |                                                                                       |        |            |
|                                               |                      | eximately 100 ml             |                       |               |                                                                                       |        |            |
|                                               | , ,                  | ater flush through the       |                       |               |                                                                                       |        |            |
|                                               | 1                    | tube (g-tube) before,        |                       |               |                                                                                       |        |            |
|                                               | during, and after    |                              |                       |               |                                                                                       |        |            |
|                                               | administration.      | In the kitchen, a piece of   |                       |               |                                                                                       |        |            |
|                                               | paper that was so    | ecured to a cabinet door     |                       |               |                                                                                       |        |            |
|                                               | contained a list of  | of medications and water     |                       |               |                                                                                       |        |            |
|                                               | flushes with time    | es to administer. The        |                       |               |                                                                                       |        |            |
|                                               | Employee E ind       | icated the spouse would      |                       |               |                                                                                       |        |            |
|                                               | sometimes have       | the medications              |                       |               |                                                                                       |        |            |
|                                               | administered pri     | or to their arrival and      |                       |               |                                                                                       |        |            |
|                                               | sometimes the cl     | linical staff would have     |                       |               |                                                                                       |        |            |
|                                               | to administer. E     | imployee E indicated she     |                       |               |                                                                                       |        |            |
|                                               | would provide g      | -tube site care after the    |                       |               |                                                                                       |        |            |
|                                               | patient received     | a bath. Employee E and       |                       |               |                                                                                       |        |            |
|                                               | 1 *                  | ssed using the Trilogy       |                       |               |                                                                                       |        |            |
|                                               | -                    | machine for oxygen           |                       |               |                                                                                       |        |            |
|                                               | rescue.              | 7.5                          |                       |               |                                                                                       |        |            |
|                                               |                      |                              |                       |               |                                                                                       |        |            |
|                                               | B. Review            | of the skilled nursing visit |                       |               |                                                                                       |        |            |
|                                               | notes indicated t    | •                            |                       |               |                                                                                       |        |            |
|                                               | notes marcarea t     | ne reme wing.                |                       |               |                                                                                       |        |            |
|                                               | 1 On 4               | /27, 4/28, 5/2, 5/3, 5/4,    |                       |               |                                                                                       |        |            |
|                                               |                      | 0, 5/11, 5/15, 5/16,         |                       |               |                                                                                       |        |            |
|                                               |                      | 5/23, 5/24, 5/25, 5/30,      |                       |               |                                                                                       |        |            |
|                                               |                      | 2/17, the visit notes        |                       |               |                                                                                       |        |            |
|                                               | i i                  | lled nurse administered      |                       |               |                                                                                       |        |            |
|                                               | tube feedings an     |                              |                       |               |                                                                                       |        |            |
|                                               | tube recuiligs all   | a water musiles.             |                       |               |                                                                                       |        |            |
|                                               |                      |                              |                       |               |                                                                                       |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 205 of 247

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                | UILDING                                                                             | 00                  | COMPL<br>06/05                                                                                                         | ETED |                      |
|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|------|----------------------|
|                                                                                | PROVIDER OR SUPPLIEF                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                     |                                                                                                                        |      |                      |
|                                                                                | 1                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                |                                                                                     |                     | AFOLIS, IN 40250                                                                                                       |      |                      |
| (X4) ID<br>PREFIX<br>TAG                                                       | (EACH DEFICIEN                                                                                                                                                                                | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                             |                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE  | (X5) COMPLETION DATE |
|                                                                                | 2 On 5                                                                                                                                                                                        | /25, 5/30, 5/31, 6/1 and                                                                                                                                                                                                                                                                                       |                                                                                     |                     |                                                                                                                        |      |                      |
|                                                                                |                                                                                                                                                                                               | notes indicated the                                                                                                                                                                                                                                                                                            |                                                                                     |                     |                                                                                                                        |      |                      |
|                                                                                | •                                                                                                                                                                                             | ovided g-tube site care.                                                                                                                                                                                                                                                                                       |                                                                                     |                     |                                                                                                                        |      |                      |
|                                                                                | include g-tube sifterquency of waname, amount, a feedings per g-tuoxygen saturation use of the Trilog machine for oxy  4. The clinical r SOC 11/21/16, if the certification 5/19/17, with ore | failed to be updated to ite care, the amount and ter flushes per g-tube, the and frequency of tube abe, when to obtain ons, and instruction on the sy vent and bypap gen rescue.  The ecord for patient #5, included a plan of care for period of 3/19/17 to ders for home health aide hours per day, 5 days a |                                                                                     |                     |                                                                                                                        |      |                      |
|                                                                                | visit notes during period, the home services approxionate hours. The durate be patient specific minimal hours proposed health aide to be would determine in a day should to be needed for the |                                                                                                                                                                                                                                                                                                                |                                                                                     |                     |                                                                                                                        |      |                      |
|                                                                                | -                                                                                                                                                                                             | of care indicated skilled oxygen saturations as                                                                                                                                                                                                                                                                |                                                                                     |                     |                                                                                                                        |      |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 206 of 247

| STATEMEN    | NT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ` ′  |          | NSTRUCTION                                                           | (X3) DATE S | SURVEY     |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|----------|----------------------------------------------------------------------|-------------|------------|
| AND PLAN    | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |      | JILDING  | 00                                                                   | COMPLE      |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | B. W | ING      |                                                                      | 06/05/2     | 2017       |
| NAME OF I   | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | •    | STREET A | DDRESS, CITY, STATE, ZIP CODE                                        |             |            |
| TO THE OF T | NO VIDER OR SOLVER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          | 82ND ST STE 216                                                      |             |            |
| AT HOM      | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |      | INDIAN   | APOLIS, IN 46250                                                     |             |            |
| (X4) ID     | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      | ID       | PROVIDER'S PLAN OF CORRECTION                                        |             | (X5)       |
| PREFIX      | ``                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ICY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE          | COMPLETION |
| TAG         | <del> </del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      | TAG      | DEFICIENCY)                                                          |             | DATE       |
|             | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | obtain oxygen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |      |          |                                                                      |             |            |
|             | saturations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
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|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |          |                                                                      |             |            |
|             | · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |          |                                                                      |             |            |
|             | times per week                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | for the instillation of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |      |          |                                                                      |             |            |
|             | medication / irri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | gation solution via                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |      |          |                                                                      |             |            |
|             | catheter into bla                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | dder every visit. The                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |      |          |                                                                      |             |            |
|             | medication profi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ile evidenced Clorpactin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |          |                                                                      |             |            |
|             | to be administer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ed every Monday,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |      |          |                                                                      |             |            |
|             | Wednesday, and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Friday via urostomy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |      |          |                                                                      |             |            |
|             | flush and order                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | for skilled nursing to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |      |          |                                                                      |             |            |
|             | obtain oxygen sa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | aturations as needed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | A. Review                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | of the skilled nursing visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      |          |                                                                      |             |            |
|             | notes on 3/31, 4/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | /3, 4/5, 4/7, 4/10, 4/12,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |          |                                                                      |             |            |
|             | 4/14, 4/12, 4/19,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4/21, 4/24, 4/26, 4/28,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | · · · · · · · · · · · · · · · · · · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | to evidence that the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |      |          |                                                                      |             |            |
|             | instillation of the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | e medication / irrigation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | · ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | Page 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | B. The Dire                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ector of Clinical Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |      |          |                                                                      |             |            |
|             | indicate when to saturations.  5. The clinical respective solution into the saturations.  5. The clinical respective solutions.  5. The clinical respective solutions.  5. The clinical respective solutions.  5. The clinical respective solution into the saturation of solutions.  5. The clinical respective solution solution profit in the saturation of solution profit in the solution of solution of the solution of the solution via catholic solution via catholic solution into the solution. The solution is solution into the solution into the solution into the solution into the solution. The solution is solution into the solution into the solution into the solution into the solution. The solution is solution into the solution int | record for patient #6, included a plan of care for period of 3/31/17 to ders for skilled nursing 1 to 2 hours per visit, 3 for the instillation of gation solution via dder every visit. The file evidenced Clorpactined every Monday, 1 Friday via urostomy for skilled nursing to aturations as needed.  of the skilled nursing visit /3, 4/5, 4/7, 4/10, 4/12, 4/21, 4/24, 4/26, 4/28, 5, 5/10, 5/12, 5/15, 5/17, 5/26, and 5/29/17, the 1 to evidence that the e medication / irrigation letter into the bladder had |      |          |                                                                      |             |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 207 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                 | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                                                                                                                                                                                       | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                  |                      |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                                                                            | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                         |                                                                                                                                                                                                                                                  | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>IAPOLIS, IN 46250                                                 |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN                                                                                                                                  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                                                                            | order dated 3/2/1 discontinue the 0                                                                                                             | 17, indicated to Clorpactin instillation.                                                                                                                                                                                                        |                     |                                                                                                                        |                      |
|                                                                                                            |                                                                                                                                                 | ng a home visit on 6/2/17 patient was observed to ome.                                                                                                                                                                                           |                     |                                                                                                                        |                      |
|                                                                                                            | exclude the Clor<br>instillation / irrig<br>when to obtain of<br>failed to include                                                              | failed to be updated to pactin medication gation, failed to indicate oxygen saturations and that the patient resided vices within a group                                                                                                        |                     |                                                                                                                        |                      |
|                                                                                                            | SOC 12/31/16, i the certification 6/7/17, with order                                                                                            | ecord for patient #7,<br>ncluded a plan of care for<br>period of 4/9/17 to<br>ers for home health aide<br>hours per day, 7 days a                                                                                                                |                     |                                                                                                                        |                      |
|                                                                                                            | visit notes during period, the home services approxi hours. The dura be patient specific minimal hours period health aide to be would determine | of the home health aide g this certification health aide provided mately from 3.5 to 6 tions of hours failed to fic and include the er day for the home in the home and who hed the duration of hours he home health aide not he entire 6 hours. |                     |                                                                                                                        |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 208 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) M                                                      | ULTIPLE CO | NSTRUCTION | (X3) DATE S                                                                            | SURVEY |            |
|------------------------------------------------------|----------------------|-------------------------------------------------------------|------------|------------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:                                      |            | JILDING    | 00                                                                                     | COMPL  | ETED       |
|                                                      |                      | 15K064                                                      | B. W       | ING        |                                                                                        | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF |                                                             | _          | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                                         | •      |            |
|                                                      |                      |                                                             |            | 6525 E     | 82ND ST STE 216                                                                        |        |            |
| AT HOM                                               | E HEALTH SERVIC      | CES LLC                                                     |            | INDIAN     | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID                                              |                      | TATEMENT OF DEFICIENCIES                                    |            | ID         | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)       |
| PREFIX                                               | `                    | ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION) |            | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  |                      | ,                                                           | +          | TAG        | BEI ICIENCT)                                                                           |        | DATE       |
|                                                      | _                    | of care indicated skilled                                   |            |            |                                                                                        |        |            |
|                                                      | _                    | n oxygen saturations as                                     |            |            |                                                                                        |        |            |
|                                                      | _                    | n of care failed to                                         |            |            |                                                                                        |        |            |
|                                                      | indicate when to     | obtain oxygen                                               |            |            |                                                                                        |        |            |
|                                                      | saturations.         |                                                             |            |            |                                                                                        |        |            |
|                                                      | C. Review            | of a recertification                                        |            |            |                                                                                        |        |            |
|                                                      |                      | assessment dated 4/7/17,                                    |            |            |                                                                                        |        |            |
|                                                      | •                    | l Services" narrative                                       |            |            |                                                                                        |        |            |
|                                                      | section indicated    |                                                             |            |            |                                                                                        |        |            |
|                                                      |                      | health services with a                                      |            |            |                                                                                        |        |            |
|                                                      | _                    | y for wound treatments.                                     |            |            |                                                                                        |        |            |
|                                                      |                      | failed to evidence that                                     |            |            |                                                                                        |        |            |
|                                                      | •                    | ands were being managed                                     |            |            |                                                                                        |        |            |
|                                                      | by a Medicare a      |                                                             |            |            |                                                                                        |        |            |
|                                                      | by a fricalcate a    | geney.                                                      |            |            |                                                                                        |        |            |
|                                                      | 7. The clinical r    | record for patient #8,                                      |            |            |                                                                                        |        |            |
|                                                      | SOC 8/3/16, inc      | luded a plan of care for                                    |            |            |                                                                                        |        |            |
|                                                      | the certification    | period of 3/31/17 to                                        |            |            |                                                                                        |        |            |
|                                                      |                      | ders for home health aide                                   |            |            |                                                                                        |        |            |
|                                                      | services up to 8     | hours per day, 7 days a                                     |            |            |                                                                                        |        |            |
|                                                      | week.                | 1 32                                                        |            |            |                                                                                        |        |            |
|                                                      |                      |                                                             |            |            |                                                                                        |        |            |
|                                                      | A. Review            | of the home health aide                                     |            |            |                                                                                        |        |            |
|                                                      | visit notes durin    | g this certification                                        |            |            |                                                                                        |        |            |
|                                                      | period, the home     | e health aide provided                                      |            |            |                                                                                        |        |            |
|                                                      | services approxi     | mately from 3.50 to 8                                       |            |            |                                                                                        |        |            |
|                                                      | hours. The dura      | tions of hours failed to                                    |            |            |                                                                                        |        |            |
|                                                      | be patient specif    | ic and include the                                          |            |            |                                                                                        |        |            |
|                                                      | minimal hours p      | er day for the home                                         |            |            |                                                                                        |        |            |
|                                                      | health aide to be    | in the home and who                                         |            |            |                                                                                        |        |            |
|                                                      | would determine      | ed the duration of hours                                    |            |            |                                                                                        |        |            |
|                                                      | in a day should t    | the home health aide not                                    |            |            |                                                                                        |        |            |
|                                                      | be needed for the    |                                                             |            |            |                                                                                        |        |            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                         | r í | JILDING             | NSTRUCTION  00                                                                                                          | (X3) DATE S<br>COMPL<br>06/05/ | ETED                       |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------|
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                  |     | 6525 E              | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216<br>APOLIS, IN 46250                                                   |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE                             | (X5)<br>COMPLETION<br>DATE |
|                          | nursing to obtain needed. The platindicate when to saturations.  8. Employee B, Services and Em Alternate Director had no further in documentation in findings on 6/2/10  9. Employee A, Administrator are further information the exit conference of the ex | the Director of Clinical aployee C, the Interim or of Clinical Services, aformation or in relation to the above 17 at 4:00 p.m.  the Alternate and Employee B, had no ion or documentation by ace on 6/5/17 at 3:50 p.m.  policy titled "Plan of |     |                     |                                                                                                                         |                                |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |     |                     |                                                                                                                         |                                |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 210 of 247

| STATEMEN  | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | JLTIPLE CC             | ONSTRUCTION                                                                            | (X3) DATE SURVEY |            |
|-----------|---------------------|------------------------------|--------|------------------------|----------------------------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION       | IDENTIFICATION NUMBER:       | A. BU  | JILDING                | 00                                                                                     | COMPL            | ETED       |
|           |                     | 15K064                       | B. W   | NG                     |                                                                                        | 06/05/           | 2017       |
|           |                     |                              |        | STREET A               | ADDRESS, CITY, STATE, ZIP CODE                                                         | <u> </u>         |            |
| NAME OF P | ROVIDER OR SUPPLIER |                              |        |                        | 82ND ST STE 216                                                                        |                  |            |
| AT HOME   | E HEALTH SERVIC     | ES LLC                       |        | INDIANAPOLIS, IN 46250 |                                                                                        |                  |            |
| (X4) ID   |                     | FATEMENT OF DEFICIENCIES     |        | ID                     | PROVIDER'S PLAN OF CORRECTION                                                          |                  | (X5)       |
| PREFIX    |                     | CY MUST BE PRECEDED BY FULL  |        | PREFIX                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΓE               | COMPLETION |
| TAG       |                     | LSC IDENTIFYING INFORMATION) |        | TAG                    | DEFICIENCY)                                                                            |                  | DATE       |
|           |                     | policy titled "Skilled       |        |                        |                                                                                        |                  |            |
|           | _                   | s" C - 200, indicated "      |        |                        |                                                                                        |                  |            |
|           | _                   | Nurse Regularly              |        |                        |                                                                                        |                  |            |
|           | reevaluates the c   | lients needs, and            |        |                        |                                                                                        |                  |            |
|           | coordinates the r   | necessary services "         |        |                        |                                                                                        |                  |            |
|           |                     |                              |        |                        |                                                                                        |                  |            |
| N 0545    | 410 IAC 17-14-1(a   |                              |        |                        |                                                                                        |                  |            |
| Bldg. 00  | Scope of Services   | (1)(F) Except where          |        |                        |                                                                                        |                  |            |
| Blug. 00  |                     | d to therapy only, for       |        |                        |                                                                                        |                  |            |
|           |                     | ce in the home health        |        |                        |                                                                                        |                  |            |
|           |                     | ered nurse shall do the      |        |                        |                                                                                        |                  |            |
|           | following:          |                              |        |                        |                                                                                        |                  |            |
|           | (F) Coordinate se   |                              | N O    | 5 1 5                  | Director of Nursing will in-servi                                                      | ice              | 09/25/2017 |
|           |                     | review and interview,        | N 0    | 343                    | nurses on coordinating care w                                                          |                  | 08/25/2017 |
|           |                     | to ensure that their         |        |                        | all medical agencies involved                                                          |                  |            |
|           |                     | rdinated effectively with    |        |                        | patient. Training will include                                                         |                  |            |
|           | -                   | viders serving their         |        |                        | documenting name of agency,                                                            |                  |            |
|           | •                   | of 5 records reviewed of     |        |                        | name/title of person spoke with                                                        |                  |            |
|           | patients receiving  | g outside services in a      |        |                        | payer, discipline(s), frequency duration and tasks to be provided                      |                  |            |
|           | sample of 10. (#    | 5, 6, 7, 8 and 10).          |        |                        | (To be done by 8/25/17) Director of Nursing will be                                    | .ou.             |            |
|           | Findings include    | :                            |        |                        | responsible to ensure orientati of newly hired nurses includes                         | i                |            |
|           | 1. The clinical re  | ecord of patient #5, SOC     |        |                        | training on coordinating care w                                                        |                  |            |
|           |                     | viewed and included a        |        |                        | all medical agencies involved very patient. Training will include                      | NILTI            |            |
|           | · ·                 | he certification period of   |        |                        | documenting name of agency,                                                            |                  |            |
|           |                     | 7. The plan of care          |        |                        | name/title of person spoke witl                                                        |                  |            |
|           |                     | ient was receiving           |        |                        | payer, discipline(s), frequency                                                        | ,                |            |
|           |                     | tional, and speech           |        |                        | duration and tasks to be                                                               | <b>-</b> \       |            |
|           |                     | ledicare agency and that     |        |                        | provided. (To begin by 8/25/1 Director of Nursing/designee w                           |                  |            |
|           | 1 3                 | 0 ,                          |        |                        | audit 100% of admissions,                                                              | /III             |            |
|           | •                   | ed in a group home with      |        |                        | resumptions and re-certificatio                                                        | ns               |            |
|           | •                   | ion. The clinical record     |        |                        | to monitor for compliance of                                                           |                  |            |
|           |                     | e that the agency had        |        |                        | coordinating care with other                                                           |                  |            |
|           |                     | ices with the Medicare       |        |                        | medical agencies, if there are                                                         |                  |            |
|           | agency and faile    | d to evidence                |        |                        | any. (To begin by 8/25/17)                                                             |                  |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 211 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA                    |                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                                 |          | SURVEY                                                                 |                   |            |
|-------------------------------------------------------------------------|---------------------------------------|---------------------------------------------|---------------------------------|----------|------------------------------------------------------------------------|-------------------|------------|
| AND PLAN                                                                | OF CORRECTION                         | IDENTIFICATION NUMBER:                      | A. BU                           | JILDING  | 00                                                                     | COMPL             | ETED       |
|                                                                         |                                       | 15K064                                      | B. W                            | ING      |                                                                        | 06/05/            | 2017       |
|                                                                         |                                       |                                             | <u> </u>                        | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                         |                   |            |
| NAME OF I                                                               | PROVIDER OR SUPPLIEF                  | 2                                           |                                 |          | 82ND ST STE 216                                                        |                   |            |
| ΔΤ ΗΟΜ                                                                  | E HEALTH SERVIC                       | CES II C                                    |                                 |          | IAPOLIS, IN 46250                                                      |                   |            |
|                                                                         |                                       |                                             |                                 |          | 1741 0210, 114 10200                                                   |                   |            |
| (X4) ID                                                                 |                                       | TATEMENT OF DEFICIENCIES                    |                                 | ID       | PROVIDER'S PLAN OF CORRECTION                                          |                   | (X5)       |
| PREFIX                                                                  |                                       | CY MUST BE PRECEDED BY FULL                 |                                 | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                | COMPLETION |
| TAG                                                                     |                                       | LSC IDENTIFYING INFORMATION)                | _                               | TAG      | DEFICIENCY)                                                            |                   | DATE       |
|                                                                         |                                       | h the group home of its                     |                                 |          | Director of Nursing will in-serv                                       |                   |            |
|                                                                         | expectations / de                     | elineation of duties with                   |                                 |          | nursing staff on requirement to notify MD of a patient's discha        |                   |            |
|                                                                         | the home health                       | agency.                                     |                                 |          | notify patient/caregiver of                                            | ıy <del>c</del> , |            |
|                                                                         |                                       |                                             |                                 |          | discharge at least fifteen (15)                                        |                   |            |
|                                                                         | 2 The clinical r                      | ecord of patient #6, SOC                    |                                 |          | days before discharge and                                              |                   |            |
|                                                                         |                                       | riewed and included a                       |                                 |          | notifying any other agency                                             |                   |            |
|                                                                         |                                       |                                             |                                 |          | involved in patient's care of                                          |                   |            |
|                                                                         | _                                     | the certification period of                 |                                 |          | upcoming discharge of patient                                          |                   |            |
|                                                                         |                                       | 17, with orders for skilled                 |                                 |          | from agency. Nurses to docum                                           |                   |            |
|                                                                         | nursing 3 times a                     | a week and home health                      |                                 |          | these conversations in patient                                         | S                 |            |
|                                                                         | aide services 7 d                     | ays a week.                                 |                                 |          | chart. (To be completed by                                             |                   |            |
|                                                                         |                                       |                                             |                                 |          | 8/25/17) Director of Nursing will be                                   |                   |            |
|                                                                         | A. During a                           | home visit on 6/2/17 at                     |                                 |          | responsible to ensure orientati                                        | on                |            |
|                                                                         | _                                     | itient was observed to                      |                                 |          | of newly hired nurses includes                                         |                   |            |
|                                                                         |                                       |                                             |                                 |          | training on requirement to noti                                        |                   |            |
|                                                                         |                                       | ome. The clinical record                    |                                 |          | MD of a patient's discharge, no                                        | •                 |            |
|                                                                         |                                       | e that the agency had                       |                                 |          | patient/caregiver of discharge                                         | at                |            |
|                                                                         |                                       | ices with the group home                    |                                 |          | least fifteen (15) days before                                         |                   |            |
|                                                                         | of its expectation                    | ns / delineation of duties                  |                                 |          | discharge and notifying any ot                                         |                   |            |
|                                                                         | with the home h                       | ealth agency.                               |                                 |          | agency involved in patient's ca                                        |                   |            |
|                                                                         |                                       |                                             |                                 |          | of upcoming discharge of patie<br>from agency. Nurses to docum         |                   |            |
|                                                                         | 3. The clinical r                     | ecord for patient #7,                       |                                 |          | these conversations in patient                                         |                   |            |
|                                                                         |                                       | ncluded a plan of care for                  |                                 |          | chart. (To begin by 8/25/17)                                           | 5                 |            |
|                                                                         |                                       | period of 4/9/17 to                         |                                 |          | Director of Nursing/designee v                                         | vill              |            |
|                                                                         |                                       | _                                           |                                 |          | audit 100% of discharges to                                            |                   |            |
|                                                                         |                                       | ers for home health aide                    |                                 |          | ensure compliance with notifyi                                         | ng                |            |
|                                                                         | •                                     | hours per day, 7 days a                     |                                 |          | MD of upcoming discharge,                                              |                   |            |
|                                                                         | week.                                 |                                             |                                 |          | notifying patient of discharge a                                       | at                |            |
|                                                                         |                                       |                                             |                                 |          | least fifteen (15) days before                                         |                   |            |
|                                                                         | A. Review                             | of a recertification                        |                                 |          | discharge and notifying other agencies involved in patient's           |                   |            |
|                                                                         | comprehensive a                       | assessment dated 4/7/17,                    |                                 |          | care of patient's upcoming                                             |                   |            |
|                                                                         |                                       | l Services" narrative                       |                                 |          | discharge from agency. (To be                                          | egin              |            |
|                                                                         |                                       |                                             |                                 |          | 8/25/17)                                                               | _                 |            |
| section indicated the patient was receiving home health services with a |                                       |                                             | The Director of Nursing will be |          |                                                                        |                   |            |
|                                                                         |                                       |                                             |                                 |          | responsible for monitoring the                                         |                   |            |
|                                                                         | Medicare agency for wound treatments. |                                             |                                 |          | corrective actions to ensure th                                        |                   |            |
|                                                                         | ^                                     | ive assessment failed to                    |                                 |          | this deficiency is corrected and                                       | d                 |            |
|                                                                         | evidence an com                       | plete skin assessment,                      |                                 |          | will not recur.                                                        |                   |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE           |                                                                         |         | SURVEY                                            |        |      |
|------------------------------------------------------|--------------------------------|------------------------------------------------|-------------------------------------------------------------------------|---------|---------------------------------------------------|--------|------|
| AND PLAN                                             | OF CORRECTION                  | IDENTIFICATION NUMBER:                         | A. BU                                                                   | JILDING | 00                                                | COMPL  | ETED |
|                                                      |                                | 15K064                                         | B. W                                                                    | ING     |                                                   | 06/05/ | 2017 |
|                                                      | PROVIDER OR SUPPLIER           |                                                | <u> </u>                                                                | 6525 E  | ADDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216 |        |      |
| AT HOM                                               | E HEALTH SERVIC                | CES LLC                                        |                                                                         | INDIAN. | APOLIS, IN 46250                                  |        |      |
| (X4) ID                                              |                                | TATEMENT OF DEFICIENCIES                       |                                                                         | ID      | PROVIDER'S PLAN OF CORRECTION                     |        | (X5) |
| PREFIX<br>TAG                                        | CROSS-REFERENCED TO THE APPROX |                                                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA' | TE      | COMPLETION                                        |        |      |
| TAG                                                  |                                | · · · · · · · · · · · · · · · · · · ·          |                                                                         | IAG     | DEFICIENCY)                                       |        | DATE |
|                                                      | _                              | site, of the patient's inical record failed to |                                                                         |         |                                                   |        |      |
|                                                      |                                | empted coordination with                       |                                                                         |         |                                                   |        |      |
|                                                      | the Medicare ag                | -                                              |                                                                         |         |                                                   |        |      |
|                                                      | the Medicare ag                | chey.                                          |                                                                         |         |                                                   |        |      |
|                                                      | B A comm                       | unication log dated                            |                                                                         |         |                                                   |        |      |
|                                                      |                                | I that the patient was                         |                                                                         |         |                                                   |        |      |
|                                                      |                                | health services with a                         |                                                                         |         |                                                   |        |      |
|                                                      | _                              | are agency for the                             |                                                                         |         |                                                   |        |      |
|                                                      |                                | ands. The clinical record                      |                                                                         |         |                                                   |        |      |
|                                                      |                                | e that the agency had                          |                                                                         |         |                                                   |        |      |
|                                                      |                                | rices with the correct                         |                                                                         |         |                                                   |        |      |
|                                                      | Medicare agency                | у.                                             |                                                                         |         |                                                   |        |      |
|                                                      |                                |                                                |                                                                         |         |                                                   |        |      |
|                                                      | 4. The clinical r              | record for patient #8,                         |                                                                         |         |                                                   |        |      |
|                                                      | SOC 8/3/16, inc                | luded a plan of care for                       |                                                                         |         |                                                   |        |      |
|                                                      | the certification              | period of 3/31/17 to                           |                                                                         |         |                                                   |        |      |
|                                                      | 5/29/17, with or               | ders for a home health                         |                                                                         |         |                                                   |        |      |
|                                                      | aide up to 8 hour              | rs a day, 7 days a week.                       |                                                                         |         |                                                   |        |      |
|                                                      | The plan of care               | indicated the patient was                      |                                                                         |         |                                                   |        |      |
|                                                      | receiving skilled              | nursing and home health                        |                                                                         |         |                                                   |        |      |
|                                                      | aide services wit              | th a Medicare agency.                          |                                                                         |         |                                                   |        |      |
|                                                      |                                | 0.1 0.10-7                                     |                                                                         |         |                                                   |        |      |
|                                                      |                                | of the OASIS start of care                     |                                                                         |         |                                                   |        |      |
|                                                      |                                | assessment dated 8/3/16,                       |                                                                         |         |                                                   |        |      |
|                                                      |                                | l Services" narrative                          |                                                                         |         |                                                   |        |      |
|                                                      | _                              | tient was receiving home                       |                                                                         |         |                                                   |        |      |
|                                                      |                                | times a week through a                         |                                                                         |         |                                                   |        |      |
|                                                      |                                | y for management of                            |                                                                         |         |                                                   |        |      |
|                                                      | _                              | s to the patient's right arm                   |                                                                         |         |                                                   |        |      |
|                                                      | and buttocks.                  |                                                |                                                                         |         |                                                   |        |      |
|                                                      | D Danie                        | of the OASIS                                   |                                                                         |         |                                                   |        |      |
|                                                      |                                | of the OASIS                                   |                                                                         |         |                                                   |        |      |
|                                                      | comprehensive i                | recertification assessment                     |                                                                         |         |                                                   |        |      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 213 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) M                       | ULTIPLE CO | NSTRUCTION | (X3) DATE S                                                             |        |            |
|------------------------------------------------------|----------------------|------------------------------|------------|------------|-------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:       |            | JILDING    | 00                                                                      | COMPL  |            |
|                                                      |                      | 15K064                       | B. W       | ING        |                                                                         | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | 3                            | •          | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                          |        |            |
|                                                      |                      |                              |            |            | 82ND ST STE 216                                                         |        |            |
| AT HOM                                               | E HEALTH SERVIC      | CES LLC                      |            | INDIAN     | APOLIS, IN 46250                                                        |        |            |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES     |            | ID         | PROVIDER'S PLAN OF CORRECTION                                           |        | (X5)       |
| PREFIX                                               |                      |                              |            | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA' | TE     | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION) | _          | TAG        | DEFICIENCY)                                                             |        | DATE       |
|                                                      |                      | 3/30/17, the "Professional   |            |            |                                                                         |        |            |
|                                                      |                      | ive indicated the patient    |            |            |                                                                         |        |            |
|                                                      |                      | tilled nursing and home      |            |            |                                                                         |        |            |
|                                                      |                      | ces through a Medicare       |            |            |                                                                         |        |            |
|                                                      | , ,                  | nical record failed to       |            |            |                                                                         |        |            |
|                                                      |                      | e agency had coordinated     |            |            |                                                                         |        |            |
|                                                      | services with the    | e Medicare agency.           |            |            |                                                                         |        |            |
|                                                      | 5. The clinical r    | record for #10, SOC (start   |            |            |                                                                         |        |            |
|                                                      |                      | , was reviewed and           |            |            |                                                                         |        |            |
|                                                      | included a plan      | •                            |            |            |                                                                         |        |            |
|                                                      | _                    | 3/7/17 to 5/5/17, with       |            |            |                                                                         |        |            |
|                                                      |                      | health aide services up to   |            |            |                                                                         |        |            |
|                                                      |                      | lays a week to assist with   |            |            |                                                                         |        |            |
|                                                      |                      | athing, dressing, activities |            |            |                                                                         |        |            |
|                                                      | •                    | neal prep, medication        |            |            |                                                                         |        |            |
|                                                      |                      | ght housekeeping per         |            |            |                                                                         |        |            |
|                                                      | care plan.           | ght housekeeping per         |            |            |                                                                         |        |            |
|                                                      | care plan.           |                              |            |            |                                                                         |        |            |
|                                                      | A. The clin          | ical record evidenced a      |            |            |                                                                         |        |            |
|                                                      | discharge OASI       | S discharge assessment       |            |            |                                                                         |        |            |
|                                                      | dated 4/2/17. Tl     | he clinical record failed    |            |            |                                                                         |        |            |
|                                                      | to evidenced tha     | t the attending physician    |            |            |                                                                         |        |            |
|                                                      |                      | d in advance of the          |            |            |                                                                         |        |            |
|                                                      | patient's unsched    | duled discharge, the         |            |            |                                                                         |        |            |
|                                                      | _                    | informed in advance of       |            |            |                                                                         |        |            |
|                                                      | -                    | d failed to provide          |            |            |                                                                         |        |            |
|                                                      | _                    | n regards notifying the      |            |            |                                                                         |        |            |
|                                                      |                      | th agency and verifying      |            |            |                                                                         |        |            |
|                                                      |                      | ces being provided.          |            |            |                                                                         |        |            |
|                                                      |                      |                              |            |            |                                                                         |        |            |
|                                                      | B. An inter          | view with the Employee       |            |            |                                                                         |        |            |
|                                                      | C, Interim Assis     | tant Director of Clinical    |            |            |                                                                         |        |            |
|                                                      |                      | 1/17 at 2:30 p.m., the       |            |            |                                                                         |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 214 of 247

|           | IT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA             | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED |                                                                     |        |            |
|-----------|----------------------|----------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|--------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:                 | A. BUILDING                                                         | 00                                                                  |        |            |
|           |                      | 15K064                                 | B. WING                                                             |                                                                     | 06/05/ | 2017       |
| NAME OF P | PROVIDER OR SUPPLIER |                                        |                                                                     | ADDRESS, CITY, STATE, ZIP CODE                                      |        |            |
|           |                      |                                        |                                                                     | 82ND ST STE 216                                                     |        |            |
| AT HOMI   | E HEALTH SERVIC      | EES LLC                                | INDIAN                                                              | APOLIS, IN 46250                                                    |        |            |
| (X4) ID   |                      | TATEMENT OF DEFICIENCIES               | ID                                                                  | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX    | ``                   | CY MUST BE PRECEDED BY FULL            | PREFIX                                                              | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG       |                      | LSC IDENTIFYING INFORMATION)           | TAG                                                                 | DEFICIENCY)                                                         |        | DATE       |
|           |                      | ted the patient notified               |                                                                     |                                                                     |        |            |
|           |                      | ndicated another home                  |                                                                     |                                                                     |        |            |
|           |                      | as in the home. At Home                |                                                                     |                                                                     |        |            |
|           |                      | decided to discharge the               |                                                                     |                                                                     |        |            |
|           |                      | ployee indicated a 15 day              |                                                                     |                                                                     |        |            |
|           | notice was not pr    | rovided.                               |                                                                     |                                                                     |        |            |
|           | _                    |                                        |                                                                     |                                                                     |        |            |
|           |                      | /17 at 2:30 p.m.,                      |                                                                     |                                                                     |        |            |
|           |                      | s not unable to provide                |                                                                     |                                                                     |        |            |
|           | any further docu     | mentation upon request.                |                                                                     |                                                                     |        |            |
|           |                      |                                        |                                                                     |                                                                     |        |            |
|           |                      | with Employee B, the                   |                                                                     |                                                                     |        |            |
|           | Director of Clini    |                                        |                                                                     |                                                                     |        |            |
|           | Employee C indi      | icated they are aware of               |                                                                     |                                                                     |        |            |
|           | the care coordinate  | ation component and                    |                                                                     |                                                                     |        |            |
|           | acknowledged th      | ne agency had a problem                |                                                                     |                                                                     |        |            |
|           | with documentat      | tion of all conversations              |                                                                     |                                                                     |        |            |
|           | and coordination     | is.                                    |                                                                     |                                                                     |        |            |
|           |                      |                                        |                                                                     |                                                                     |        |            |
|           | 7. An undated p      |                                        |                                                                     |                                                                     |        |            |
|           |                      | f Client Services" C -                 |                                                                     |                                                                     |        |            |
|           | 360, indicated "I    | t shall be the policy of               |                                                                     |                                                                     |        |            |
|           | this agency to en    | sure effective                         |                                                                     |                                                                     |        |            |
|           | interchange, repo    | orting and coordination                |                                                                     |                                                                     |        |            |
|           | of care and infor    | mation provided by                     |                                                                     |                                                                     |        |            |
|           | other providers of   | of care "                              |                                                                     |                                                                     |        |            |
|           |                      | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |                                                                     |                                                                     |        |            |
| N 0554    | 410 IAC 17-14-1(a    |                                        |                                                                     |                                                                     |        |            |
| Bldg. 00  | Scope of Services    | (2) (B) For purposes of                |                                                                     |                                                                     |        |            |
| Biug. 00  |                      | ne health setting, the                 |                                                                     |                                                                     |        |            |
|           | licensed practical   | •                                      |                                                                     |                                                                     |        |            |
|           | following:           |                                        |                                                                     |                                                                     |        |            |
|           | (B) Prepare clinic   |                                        | N. 0554                                                             | Director of Nursing will in a                                       | ioo    | 00/25/2015 |
|           |                      | review and interview,                  | N 0554                                                              | Director of Nursing will in-serv<br>nurses on requirement to follo  |        | 08/25/2017 |
|           | the agency failed    | d to ensure the Licensed               |                                                                     | Tidi 303 On requirement to 10110                                    | vv     |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 215 of 247

| STATEMEN                                                            | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION |                                |                                                                         | (X3) DATE SURVEY |  |
|---------------------------------------------------------------------|------------------------------------------------------|------------------------------|----------------------------|--------------------------------|-------------------------------------------------------------------------|------------------|--|
| AND PLAN                                                            | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU                      | JILDING                        | 00                                                                      | COMPLETED        |  |
|                                                                     |                                                      | 15K064                       | B. W                       | ING                            |                                                                         | 06/05/2017       |  |
|                                                                     |                                                      |                              |                            | STREET /                       | ADDRESS, CITY, STATE, ZIP CODE                                          |                  |  |
| NAME OF F                                                           | PROVIDER OR SUPPLIEF                                 | 8                            |                            |                                | 82ND ST STE 216                                                         |                  |  |
| AT HOM                                                              | E HEALTH SERVIC                                      | ES II C                      |                            |                                | APOLIS, IN 46250                                                        |                  |  |
| AT HOW                                                              | E HEALTH SERVIC                                      | LES LLC                      |                            | INDIAN                         | APOLIS, IN 40250                                                        |                  |  |
| (X4) ID                                                             | SUMMARY S                                            | TATEMENT OF DEFICIENCIES     |                            | ID                             | PROVIDER'S PLAN OF CORRECTION                                           | (X5)             |  |
| PREFIX                                                              | (EACH DEFICIEN                                       | CY MUST BE PRECEDED BY FULL  |                            | PREFIX                         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA' |                  |  |
| TAG                                                                 | REGULATORY OR                                        | LSC IDENTIFYING INFORMATION) |                            | TAG                            | DEFICIENCY)                                                             | DATE             |  |
|                                                                     | Practical Nurse (                                    | (LPN) documented on a        |                            |                                | Plan of Care which includes ta                                          | sks              |  |
|                                                                     | patient's urostom                                    | ny care and bowel            |                            |                                | nurse is to provide.                                                    |                  |  |
|                                                                     | program in 1 of                                      | 4 active records reviewed    |                            |                                | Care documented must follow orders on Plan of Care. Nurse               | s to             |  |
|                                                                     |                                                      | skillned nursing in a        |                            |                                | document how patient tolerate                                           |                  |  |
|                                                                     | sample of 10. (#                                     | •                            |                            |                                | the procedure being done. (To                                           |                  |  |
|                                                                     | sample of 10. (n                                     | (10)                         |                            |                                | completed by 8/25/17)                                                   |                  |  |
|                                                                     | T: 1: : 1 1                                          |                              |                            |                                |                                                                         |                  |  |
|                                                                     | Findings include                                     | );                           |                            |                                | Director of Nursing will be                                             |                  |  |
|                                                                     |                                                      |                              |                            |                                | responsible to ensure orientati                                         |                  |  |
|                                                                     | 1. The clinical r                                    | ecord for patient #6,        |                            |                                | of newly hired nurses includes                                          |                  |  |
|                                                                     | SOC 1/30/17, ir                                      | cluded a plan of care for    |                            |                                | training on requirement to follo                                        |                  |  |
|                                                                     | the certification                                    | period of 3/31/17 to         |                            |                                | Plan of Care. Care documente must follow orders on Plan of              | ea               |  |
|                                                                     | ·                                                    | ders for skilled nursing 1   |                            |                                | Care. Nurses to document how                                            | v                |  |
|                                                                     |                                                      | to 2 hours per visit, 3      |                            |                                | patient tolerated the procedure                                         |                  |  |
|                                                                     |                                                      | o remove and apply a         |                            |                                | being done. (To begin by 8/25                                           | •                |  |
|                                                                     | _                                                    |                              |                            |                                | Director of Nursing/designee v                                          |                  |  |
|                                                                     | 1                                                    | one day per week and for     |                            |                                | audit 100% of nursing                                                   |                  |  |
|                                                                     |                                                      | f medication / irrigation    |                            |                                | documentation weekly, until                                             |                  |  |
|                                                                     | solution via cath                                    | eter into bladder every      |                            |                                | 100% compliance is achieved,                                            | •                |  |
|                                                                     | visit. The medic                                     | eation profile evidenced     |                            |                                | monitor compliance with follow                                          |                  |  |
|                                                                     | Clorpactin to be                                     | administered every           |                            |                                | MD ordered plan of care and t<br>care provided follows the MD           | liat             |  |
|                                                                     | Monday, Wedne                                        | sday, and Friday via         |                            |                                | ordered Plan of Care and that                                           |                  |  |
|                                                                     | <u>-</u>                                             | and order for skilled        |                            |                                | nurses document how patient                                             |                  |  |
|                                                                     |                                                      | oxygen saturations as        |                            |                                | tolerated the procedure being                                           |                  |  |
|                                                                     | needed.                                              | Toxygen saturations as       |                            |                                | done. Once 100% compliance                                              | is               |  |
|                                                                     | needed.                                              |                              |                            |                                | achieved, Director of                                                   |                  |  |
|                                                                     |                                                      |                              |                            |                                | Nursing/designee will audit 25                                          |                  |  |
|                                                                     |                                                      | of the skilled nursing visit |                            |                                | of nursing documentation mon                                            | thly             |  |
|                                                                     | notes on 3/31, 4/                                    | /3, 4/5, 4/7, 4/10, 4/12,    |                            |                                | to monitor for continued compliance. (To begin by                       |                  |  |
|                                                                     | 4/14, 4/19, 4/21,                                    | 4/24, 4/26, 4/28, 5/1,       |                            |                                | 8/25/17)                                                                |                  |  |
|                                                                     | 5/3, 5/5, 5/8, 5/1                                   | 0, 5/12, 5/15, 5/17, 5/19,   |                            |                                | Director of Nursing will be                                             |                  |  |
|                                                                     | 5/22, 5/24, 5/26.                                    | and 5/29/17, failed to       |                            |                                | responsible for monitoring the                                          | se               |  |
|                                                                     |                                                      |                              |                            |                                | corrective changes to ensure t                                          |                  |  |
| evidence that the patient's urostomy wafer had been changed weekly. |                                                      |                              |                            | deficiency is corrected and do | es                                                                      |                  |  |
|                                                                     | water had been t                                     | manged weekly.               |                            |                                | not recur.                                                              |                  |  |
|                                                                     | D D .                                                | 64 131 1                     |                            |                                |                                                                         |                  |  |
|                                                                     |                                                      | of the skilled nursing visit |                            |                                |                                                                         |                  |  |
|                                                                     | I notes on 3/31 4/                                   | /3 4/5 4/7 4/10 4/14         |                            |                                |                                                                         |                  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 216 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE C A. BUILDING B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ONSTRUCTION  00                                                                     | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                             |    |                    |  |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----|--------------------|--|
|                                                                                                            | PROVIDER OR SUPPLIEI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                   |    |                    |  |
| (X4) ID<br>PREFIX                                                                                          | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSO IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX                                                                        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | BE | (X5)<br>COMPLETION |  |
| TAG                                                                                                        | 4/21, 4/24, 4/26, 5/10, 5/12, 5/15, 5/26, and 5/29/1 indicated an 18 inserted with urifailed to include double lumen for C. Review visit notes on 3/4, 4/24, 4/26, 5/10, 5/12, 5/15, 5/26, and 5/29/1 the patient's bow conducted, the oprogram, and the the procedures.  D. The Director of Conducted and the particular order dated 3/2/discontinued and the conducted and the particular order dated 3/2/discontinued the conducted and the particular order dated 3/2/discontinued and the conducted and the particular order dated 3/2/discontinued and the conducted and the particular order dated 3/2/discontinued and the conducted and the particular order dated 3/2/discontinued and the conducted and the particular order dated 3/2/discontinued and the conducted and the particular order of Conducted and the particular order | ALSC IDENTIFYING INFORMATION)  A4/28, 5/1, 5/3, 5/5, 5/8, 5/17, 5/19, 5/22, 5/24, 7, the visit notes Fr foley catheter had been ne return. The notes where and why the ley catheter insertion.  of the skilled nursing 31, 4/3, 4/5, 4/10, 4/14, 4/28, 5/1, 5/3, 5/5, 5/8, 5/17, 5/19, 5/22, 5/24, 7, failed to evidence that wel program had been outcome of the bowel the patient's tolerance of  ector of Clinical Services on 06/05/17 at 1:30 and tient's Clorpactin the bladder had been the Director of Clinical the d a physician's script / 17, indicated to Clorpactin instillation.  ernate Administrator and Clinical Services had not ion or documentation by nee on 06/05/17 at 3:50 | TAG                                                                                 | DEPCIENCE                                                                                                         |    | DATE               |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 217 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O |                                                          | X1) PROVIDER/SUPPLIER/CLIA                                                                                           | (X2) MULTIPLE CONSTRUCTION (X3) DATE S                                                    |         | SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        |            |
|---------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                          | OF CORRECTION                                            | IDENTIFICATION NUMBER:                                                                                               | A. BU                                                                                     | JILDING | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | COMPL  | ETED       |
|                                                   |                                                          | 15K064                                                                                                               | B. Wl                                                                                     | NG      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 06/05/ | 2017       |
|                                                   | PROVIDER OR SUPPLIEF                                     |                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        |            |
| (X4) ID                                           | SUMMARY S                                                | TATEMENT OF DEFICIENCIES                                                                                             |                                                                                           | ID      | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        | (X5)       |
| PREFIX                                            | `                                                        | CY MUST BE PRECEDED BY FULL                                                                                          |                                                                                           | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | TE     | COMPLETION |
| TAG                                               |                                                          | LSC IDENTIFYING INFORMATION)                                                                                         | _                                                                                         | TAG     | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |        | DATE       |
|                                                   | The Licensed Pr<br>the regisered nur<br>physician plan o | s" C - 200, indicated " actical Nurse Assists rse to complete the f care for skilled services cal and progress notes |                                                                                           |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        |            |
| N 0555                                            | 410 IAC 17-14-1(a                                        | a)(2)(C)                                                                                                             |                                                                                           |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        |            |
| Bldg. 00                                          | Scope of Services                                        |                                                                                                                      | N 0555                                                                                    |         | Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To be completed by 8/25/17) Director of Nursing will be |        | 08/25/2017 |
|                                                   |                                                          |                                                                                                                      |                                                                                           |         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        |            |
|                                                   | care, transfers, n                                       | nedication reminders,                                                                                                |                                                                                           |         | responsible to ensure orientati<br>of newly hired nurses includes<br>training on requirement to follo<br>Plan of Care which includes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ;      |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 218 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION                                                                                                                                                                                                                                                                               |       | ONSTRUCTION | (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                     | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                   | A. BU | JILDING     | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | COMPLETED                                                                         |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                   | 15K064                                                                                                                                                                                                                                                                                                   | B. WI | NG          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 06/05/2017                                                                        |
| NAME OF A                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                   | <u> </u>                                                                                                                                                                                                                                                                                                 |       | STREET A    | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                   |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                          |       | 6525 E      | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                   |
|                                                      | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                          |       | l           | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |
| (X4) ID                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                 |       | ID          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5)                                                                              |
| PREFIX                                               | `                                                                                                                                                                                                                                                                                                                                                                                                                                 | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                              |       | PREFIX      | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                   |
| TAG                                                  | A. During a 1:00 p.m., Emploobserved to admi (anti-seizure meibuprofen (used fever) and approducing, and after administration. paper that was secontained a list of flushes with time Employee E indisometimes have administered prisometimes the cito administer. Ewould provide g patient received  B. Review of notes indicated to 1. On 4 5/5, 5/8, 5/9, 5/1 5/18, 5/22, 5/23, 6/1 and 6/2/17, to the skilled nurse feedings. | ater flush through the tube (g-tube) before, medication In the kitchen, a piece of ecured to a cabinet door of medications and water es to administer. icated the spouse would the medications or to their arrival and linical staff would have mployee E indicated she tube site care after the a bath. |       | TAG         | frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. visit is not made, nurse will document reason, complete a missed visit report and notify N of missed visit. If patient requir a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager of Director of Nursing to discuss patient's need before MD is contacted. (To begin by 8/25/1 Director of Nursing/designee waudit 100% of nursing documentation weekly, until 100% compliance is achieved, monitor compliance with follow frequency and duration for disciplines ordered by MD as will more than the more | If a  AID  res  t e e ot  re ot  or  7)  vill  to  ving  well  hat  00%  tor  ded |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 219 of 247

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |                                                          | ULTIPLE CO.<br>UILDING | NSTRUCTION 00 | (X3) DATE<br>COMPL                                                                    |        |            |
|-----------------------------------------------|----------------------|----------------------------------------------------------|------------------------|---------------|---------------------------------------------------------------------------------------|--------|------------|
| ANDILAN                                       | or condition         | 15K064                                                   | B. W                   |               | 00                                                                                    | 06/05/ |            |
|                                               |                      | 1011001                                                  |                        | CTDEET A      | DDRESS, CITY, STATE, ZIP CODE                                                         | 00/00/ | 2011       |
| NAME OF I                                     | PROVIDER OR SUPPLIER | 8                                                        |                        | 1             | 82ND ST STE 216                                                                       |        |            |
| AT HOM                                        | E HEALTH SERVIC      | ES LLC                                                   |                        | 1             | APOLIS, IN 46250                                                                      |        |            |
| (X4) ID                                       |                      | TATEMENT OF DEFICIENCIES                                 |                        | ID            | PROVIDER'S PLAN OF CORRECTION                                                         |        | (X5)       |
| PREFIX<br>TAG                                 | •                    | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |                        | PREFIX        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                           |                      | notes indicated the                                      |                        | TAG           | Dir lett. (C.1)                                                                       |        | DATE       |
|                                               | · /                  | ninistered water flushes.                                |                        |               |                                                                                       |        |            |
|                                               | Skilled liurse adi   | ministered water musiles.                                |                        |               |                                                                                       |        |            |
|                                               | 3 On 5               | /25, 5/30, 5/31, 6/1 and                                 |                        |               |                                                                                       |        |            |
|                                               |                      | notes indicated the                                      |                        |               |                                                                                       |        |            |
|                                               | · ·                  | vided g-tube site care.                                  |                        |               |                                                                                       |        |            |
|                                               |                      |                                                          |                        |               |                                                                                       |        |            |
|                                               | 4. On 5              | /4, 5/17, 5/25, 5/31, 6/1,                               |                        |               |                                                                                       |        |            |
|                                               | and 6/4/17, the v    | visit notes indicated the                                |                        |               |                                                                                       |        |            |
|                                               | skilled nurse wa     | s in the home for 4 hours                                |                        |               |                                                                                       |        |            |
|                                               | and for 10 hours     | on 5/23/17.                                              |                        |               |                                                                                       |        |            |
|                                               |                      |                                                          |                        |               |                                                                                       |        |            |
|                                               | 5. Thre              | e (3) skilled nursing visits                             |                        |               |                                                                                       |        |            |
|                                               | were made week       | 1 and 4 of the                                           |                        |               |                                                                                       |        |            |
|                                               | certification peri   | od and 4 skilled nursing                                 |                        |               |                                                                                       |        |            |
|                                               |                      | e week 2, 3, 5, and 6 of                                 |                        |               |                                                                                       |        |            |
|                                               | the certification    | period.                                                  |                        |               |                                                                                       |        |            |
|                                               |                      | 105 1105 1100 510 510                                    |                        |               |                                                                                       |        |            |
|                                               |                      | /25, 4/27, 4/28, 5/2, 5/3,                               |                        |               |                                                                                       |        |            |
|                                               |                      | 5,5/10,5/11,5/15,5/16,<br>5/22 - 15/24/17, Still 1       |                        |               |                                                                                       |        |            |
|                                               |                      | 5/23 and 5/24/17, failed                                 |                        |               |                                                                                       |        |            |
|                                               | provided.            | rsonal care had been                                     |                        |               |                                                                                       |        |            |
|                                               | provided.            |                                                          |                        |               |                                                                                       |        |            |
|                                               | The skilled nurse    | es failed to follow the                                  |                        |               |                                                                                       |        |            |
|                                               |                      | egards to frequency and                                  |                        |               |                                                                                       |        |            |
|                                               | _                    | s, providing personal                                    |                        |               |                                                                                       |        |            |
|                                               |                      | providing services                                       |                        |               |                                                                                       |        |            |
|                                               | without a physic     | •                                                        |                        |               |                                                                                       |        |            |
|                                               |                      |                                                          |                        |               |                                                                                       |        |            |
|                                               | 3. The clinical r    | ecord for patient #6,                                    |                        |               |                                                                                       |        |            |
|                                               | SOC 1/30/17, ir      | ncluded a plan of care for                               |                        |               |                                                                                       |        |            |
|                                               | the certification    | period of 3/31/17 to                                     |                        |               |                                                                                       |        |            |
|                                               | 5/29/17, with ord    | ders for skilled nursing 1                               |                        |               |                                                                                       |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 220 of 247

| AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15K064 |                                                                                                          | UILDING                                                                                                                                                                                               | NSTRUCTION 00       | COMPL<br>06/05/                                                                                                        | ETED |                            |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
| NAME OF I                                                                      | PROVIDER OR SUPPLIER                                                                                     |                                                                                                                                                                                                       | 1                   | DDRESS, CITY, STATE, ZIP CODE<br>82ND ST STE 216                                                                       |      |                            |
| AT HOM                                                                         | E HEALTH SERVIC                                                                                          | ES LLC                                                                                                                                                                                                | 1                   | APOLIS, IN 46250                                                                                                       |      |                            |
| (X4) ID<br>PREFIX<br>TAG                                                       | (EACH DEFICIEN                                                                                           | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE   | (X5)<br>COMPLETION<br>DATE |
|                                                                                | times per week t                                                                                         | to 2 hours per visit, 3<br>o remove and apply a<br>one day per week.                                                                                                                                  |                     |                                                                                                                        |      |                            |
|                                                                                | 3/31, 4/3, 4/5, 4/4/19, 4/21, 4/24, 5/8, 5/10, 5/12, 5/24, 5/26, and 5 failed to evidence urostomy wafer | of the LPN visit notes on 7, 4/10, 4/12, 4/14, 4/17, 4/26, 4/28, 5/1, 5/3, 5/5, 5/15, 5/17, 5/19, 5/22, 5/29/17, the visit notes be that the patient's had been changed lled nurse failed to of care. |                     |                                                                                                                        |      |                            |
|                                                                                | Services and Em<br>Alternate Direct<br>had no further in                                                 | n relation to the above                                                                                                                                                                               |                     |                                                                                                                        |      |                            |
|                                                                                | on 6/5/17 at 3:50 of hours may be being included in                                                      | de Employee B, indicated p.m., that the overage due to waiver hours the Medicaid Prior purs. Both indicated                                                                                           |                     |                                                                                                                        |      |                            |
|                                                                                | Care" C - 580, in care is a dynami the care, treatme                                                     | olicy titled "Plan of<br>ndicated " Planning for<br>c process that addresses<br>nt and services to be<br>individualized Plan of                                                                       |                     |                                                                                                                        |      |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 221 of 247

| r f           |                                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY              |                                                  |               |                                                                    |        |                    |
|---------------|-------------------------------------|----------------------------------------------------------|--------------------------------------------------|---------------|--------------------------------------------------------------------|--------|--------------------|
| AND PLAN      | OF CORRECTION                       | IDENTIFICATION NUMBER:                                   |                                                  | JILDING       | 00                                                                 | COMPL  |                    |
|               |                                     | 15K064                                                   | B. W                                             | ing           |                                                                    | 06/05/ | 2017               |
| NAME OF P     | ROVIDER OR SUPPLIER                 |                                                          |                                                  |               | ADDRESS, CITY, STATE, ZIP CODE                                     |        |                    |
|               |                                     | PECHIC                                                   | 6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250 |               |                                                                    |        |                    |
|               | E HEALTH SERVIC                     |                                                          |                                                  |               | IAPULIS, IN 4025U                                                  |        |                    |
| (X4) ID       |                                     | TATEMENT OF DEFICIENCIES                                 |                                                  | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |        | (X5)               |
| PREFIX<br>TAG | *                                   | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |                                                  | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)                     | TE     | COMPLETION<br>DATE |
| TAG           |                                     | a comprehensive                                          |                                                  | IAG           |                                                                    |        | DATE               |
|               |                                     | nformation provided by                                   |                                                  |               |                                                                    |        |                    |
|               |                                     | y and health team                                        |                                                  |               |                                                                    |        |                    |
|               | · ·                                 | Plan of Care shall be                                    |                                                  |               |                                                                    |        |                    |
|               |                                     | l to include Type,                                       |                                                  |               |                                                                    |        |                    |
|               | -                                   | luration of all visits /                                 |                                                  |               |                                                                    |        |                    |
|               |                                     | ations, treatments, and                                  |                                                  |               |                                                                    |        |                    |
|               | procedures "                        | tions, treatments, and                                   |                                                  |               |                                                                    |        |                    |
|               | procedures                          |                                                          |                                                  |               |                                                                    |        |                    |
|               | 7. An undated p                     | olicy titled "Skilled                                    |                                                  |               |                                                                    |        |                    |
|               | _                                   | s" C - 200, indicated "                                  |                                                  |               |                                                                    |        |                    |
|               | _                                   | actical Nurse Assists                                    |                                                  |               |                                                                    |        |                    |
|               | the regisered nur                   | rse to complete the                                      |                                                  |               |                                                                    |        |                    |
|               | -                                   | f care for skilled services                              |                                                  |               |                                                                    |        |                    |
|               | Prepares clinic                     | cal and progress notes                                   |                                                  |               |                                                                    |        |                    |
|               | "                                   | -                                                        |                                                  |               |                                                                    |        |                    |
|               |                                     |                                                          |                                                  |               |                                                                    |        |                    |
| N 0557        | 410 IAC 17-14-1(a                   |                                                          |                                                  |               |                                                                    |        |                    |
| Bldg. 00      | Scope of Services Rule 14 Sec. 1(a) | (2)(E) For purposes of                                   |                                                  |               |                                                                    |        |                    |
| Diag. 00      |                                     | ne health setting, the                                   |                                                  |               |                                                                    |        |                    |
|               | licensed practical                  | nurse shall do the                                       |                                                  |               |                                                                    |        |                    |
|               | following:                          | ient in learning appropriate                             |                                                  |               |                                                                    |        |                    |
|               | self-care techniqu                  | •                                                        |                                                  |               |                                                                    |        |                    |
|               | •                                   | review and interview,                                    | N 0                                              | 557           | Director of Nursing/designee v                                     | vill   | 08/25/2017         |
|               |                                     | ctical Nurse (LPN) to                                    |                                                  |               | in-service nursing staff on                                        |        |                    |
|               |                                     | skilled nursing visit                                    |                                                  |               | accurately documenting care provided specifically indicating       |        |                    |
|               |                                     | eding administered,                                      |                                                  |               | what education was done and                                        |        |                    |
|               |                                     | luid intake, specific the                                |                                                  |               | patient/caregiver response, if                                     |        |                    |
|               |                                     | was taught to the patient,                               |                                                  |               | was notified of changes or                                         |        |                    |
|               |                                     | ching, disease process                                   |                                                  |               | concerns what changes if any were ordered, explaining tasks        |        |                    |
|               | teaching, reason                    | •                                                        |                                                  |               | that were done in detail – i.e. t                                  |        |                    |
|               | _                                   | rell as the follow up on                                 |                                                  |               | feedings to include type of                                        |        |                    |
|               |                                     | cated with the patient and                               |                                                  |               | solution and amount                                                |        |                    |
|               |                                     | eation in 1 of 10 records                                |                                                  |               | administered, assessment as ordered on Plan of Care. Nurs          | es     |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 222 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV                                                                                                                                                                                                                                                                                                                                                                               |       |          | SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                         |            |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------|
| AND PLAN                                             | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                  | A. BU | JILDING  | 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | COMPL                                   | ETED       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 15K064                                                                                                                                                                                                                                                                                                                                                                                                                  | B. WI | NG       | 06/05/2017                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                         | 2017       |
|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                         |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                         |            |
| NAME OF F                                            | PROVIDER OR SUPPLIEF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 8                                                                                                                                                                                                                                                                                                                                                                                                                       |       |          | 82ND ST STE 216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |            |
| AT HOM                                               | E HEALTH SERVIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | CES LLC                                                                                                                                                                                                                                                                                                                                                                                                                 |       |          | APOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |            |
| (X4) ID                                              | SUMMARY S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                         | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                             |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ГЕ                                      | COMPLETION |
| TAG                                                  | REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                            |       | TAG      | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                         | DATE       |
| IAU                                                  | reviewed. (#4)  Findings include  1. The clinical r (start of care) 4/ The skilled nurse the following:  A. On 4/27/ indicated the interesting on new teaching, disease administered tube note failed to evidet, and disease and patient's under type and amount administered.  B. On 4/28, 5/23/17, the visit interventions produced administration of note failed to evident amount of tube for the failed to evident were endinged to evident were endinged to evident amount of tube for the failed | ecord for patient #4 SOC 26/17, was reviewed. ing visit notes indicated /17, the visit note erventions provided were medication, diet exprocess teaching and be feedings. The visit idence the medications, process that were taught derstanding as well as the extra of tube feeding /17, 5/19, 5/22 and extra total indicated the evided were the fube feedings. The visit idence the type and feedings administered. |       | IAU      | to sign documentation. (To be completed by 8/25/17) Director of Nursing is responsi to ensure orientation of newly hired nurses includes training accurately documenting care provided specifically indicating what education was done and patient/caregiver response, if N was notified of changes or concerns what changes if any were ordered, explaining tasks that were done in detail – i.e. to feedings to include type of solution and amount administered, assessment as ordered on Plan of Care. Nursito sign documentation. (To beg by 8/25/17) Director of Nursing/designee waudit 100% of visit notes week to monitor for compliance. One 100% compliance has been achieved, 25% of visit notes we audited monthly to monitor compliance. (To begin by 8/25/17). Director of Nursing will be responsible for monitoring thes corrective actions to ensure the deficiency is corrected and will not recur. | on  MD  sube  es gin vill ly ce ill for | DATE       |
|                                                      | patient's underst                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | anding of tube feedings,                                                                                                                                                                                                                                                                                                                                                                                                |       |          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 223 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION (X3) |       |          | (X3) DATE                                                                                          | SURVEY |            |
|------------------------------------------------------|----------------------|---------------------------------|-------|----------|----------------------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:          | A. BU | JILDING  | 00                                                                                                 | COMPL  | ETED       |
|                                                      |                      | 15K064                          | B. W  | ING      |                                                                                                    | 06/05/ | 2017       |
| NAME OF F                                            | DOLUBER OF GUERN IEE |                                 |       | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                     |        |            |
| NAME OF E                                            | PROVIDER OR SUPPLIEF | C .                             |       | 6525 E   | 82ND ST STE 216                                                                                    |        |            |
|                                                      | E HEALTH SERVIC      |                                 |       |          | APOLIS, IN 46250                                                                                   |        |            |
| (X4) ID                                              |                      | TATEMENT OF DEFICIENCIES        |       | ID       | PROVIDER'S PLAN OF CORRECTION                                                                      |        | (X5)       |
| PREFIX                                               | ì ·                  | ICY MUST BE PRECEDED BY FULL    |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | ΓE     | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION)    | +     | TAG      | DEFICIENCE)                                                                                        |        | DATE       |
|                                                      |                      | amount of tube feedings         |       |          |                                                                                                    |        |            |
|                                                      | administered.        |                                 |       |          |                                                                                                    |        |            |
|                                                      | D 0 5/0/1            |                                 |       |          |                                                                                                    |        |            |
|                                                      |                      | 7, the visit note indicated     |       |          |                                                                                                    |        |            |
|                                                      | the interventions    | •                               |       |          |                                                                                                    |        |            |
|                                                      |                      | lministration of tube           |       |          |                                                                                                    |        |            |
|                                                      | _                    | indicated that there were       |       |          |                                                                                                    |        |            |
|                                                      | ,                    | ges and the physician was       |       |          |                                                                                                    |        |            |
|                                                      |                      | e case manager was              |       |          |                                                                                                    |        |            |
|                                                      | informed. The v      | visit notes failed to           |       |          |                                                                                                    |        |            |
|                                                      | evidence what w      | vas educated in regards to      |       |          |                                                                                                    |        |            |
|                                                      | tube feedings, th    | e patient's understanding       |       |          |                                                                                                    |        |            |
|                                                      | of tube feedings,    | , type of tube feedings         |       |          |                                                                                                    |        |            |
|                                                      | administered, wl     | hat the specific changes        |       |          |                                                                                                    |        |            |
|                                                      | in condition was     | , and physician response        |       |          |                                                                                                    |        |            |
|                                                      | to notification of   | f said change. The visit        |       |          |                                                                                                    |        |            |
|                                                      |                      | to evidence a blood             |       |          |                                                                                                    |        |            |
|                                                      | pressure, temper     | ature, heart rate,              |       |          |                                                                                                    |        |            |
|                                                      |                      | pain assessment.                |       |          |                                                                                                    |        |            |
|                                                      | ,                    |                                 |       |          |                                                                                                    |        |            |
|                                                      | E. On 5/9            | 5/10 and 5/11/17, the visit     |       |          |                                                                                                    |        |            |
|                                                      | notes indicated t    | -                               |       |          |                                                                                                    |        |            |
|                                                      | provided were e      |                                 |       |          |                                                                                                    |        |            |
|                                                      | _                    | f tube feedings as well         |       |          |                                                                                                    |        |            |
|                                                      |                      | ere were significant            |       |          |                                                                                                    |        |            |
|                                                      |                      | physician was notified          |       |          |                                                                                                    |        |            |
|                                                      | _                    | anager was informed.            |       |          |                                                                                                    |        |            |
|                                                      |                      | ailed to evidence what          |       |          |                                                                                                    |        |            |
|                                                      |                      |                                 |       |          |                                                                                                    |        |            |
|                                                      |                      | regards to tube feedings,       |       |          |                                                                                                    |        |            |
|                                                      | _                    | erstanding of tube              |       |          |                                                                                                    |        |            |
|                                                      | " "                  | e of tube feedings              |       |          |                                                                                                    |        |            |
|                                                      | _                    | he specific changes in          |       |          |                                                                                                    |        |            |
|                                                      |                      | and physician response to       |       |          |                                                                                                    |        |            |
|                                                      | notification of sa   | aid change.                     |       |          |                                                                                                    |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 224 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | ľ í                                                      |       | NSTRUCTION | (X3) DATE                                                                              |        |            |
|------------------------------------------------------|----------------------|----------------------------------------------------------|-------|------------|----------------------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:                                   |       | JILDING    | 00                                                                                     | COMPL  |            |
|                                                      |                      | 15K064                                                   | B. W. | ING        | _                                                                                      | 06/05/ | 2017       |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | \<br>{                                                   |       |            | ADDRESS, CITY, STATE, ZIP CODE                                                         |        |            |
| A.T. L.I.O.M.                                        |                      | 250110                                                   |       |            | 82ND ST STE 216                                                                        |        |            |
| AT HOM                                               | E HEALTH SERVIC      | JES LLC                                                  |       | INDIAN     | APOLIS, IN 46250                                                                       |        |            |
| (X4) ID                                              |                      | TATEMENT OF DEFICIENCIES                                 |       | ID         | PROVIDER'S PLAN OF CORRECTION                                                          |        | (X5)       |
| PREFIX                                               |                      | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) |       | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |
| TAG                                                  | REGULATORY OR        | LISC IDENTIFY ING INFORMATION)                           |       | TAG        | BEI ICIENCT)                                                                           |        | DATE       |
|                                                      | E On 5/16            | and 5/24/17, the rejait note                             |       |            |                                                                                        |        |            |
|                                                      |                      | and 5/24/17, the visit note                              |       |            |                                                                                        |        |            |
|                                                      |                      | erventions provided were                                 |       |            |                                                                                        |        |            |
|                                                      |                      | f tube feedings. The visit                               |       |            |                                                                                        |        |            |
|                                                      |                      | idence the type of tube                                  |       |            |                                                                                        |        |            |
|                                                      | feeding administ     | tered.                                                   |       |            |                                                                                        |        |            |
|                                                      | C 0 5/05             | 1.5/20/17 .1                                             |       |            |                                                                                        |        |            |
|                                                      |                      | and 5/30/17, the visit                                   |       |            |                                                                                        |        |            |
|                                                      | notes indicated t    |                                                          |       |            |                                                                                        |        |            |
|                                                      | _                    | ducation of g-tube                                       |       |            |                                                                                        |        |            |
|                                                      | •                    | ation instruction, signs                                 |       |            |                                                                                        |        |            |
|                                                      |                      | f disease process, and                                   |       |            |                                                                                        |        |            |
|                                                      | _                    | The visit note failed to                                 |       |            |                                                                                        |        |            |
|                                                      |                      | vas educated in regards to                               |       |            |                                                                                        |        |            |
|                                                      |                      | edications, and signs /                                  |       |            |                                                                                        |        |            |
|                                                      | ' '                  | e disease process, the                                   |       |            |                                                                                        |        |            |
|                                                      | _                    | anding of the education                                  |       |            |                                                                                        |        |            |
|                                                      |                      | assessment of the g-tube                                 |       |            |                                                                                        |        |            |
|                                                      | site and the spec    | ific "care" provided.                                    |       |            |                                                                                        |        |            |
|                                                      |                      |                                                          |       |            |                                                                                        |        |            |
|                                                      |                      | ote on 5/26/17, was                                      |       |            |                                                                                        |        |            |
|                                                      | _                    | 17. The visit note was                                   |       |            |                                                                                        |        |            |
|                                                      | incomplete and       |                                                          |       |            |                                                                                        |        |            |
|                                                      | cardiovascular, §    |                                                          |       |            |                                                                                        |        |            |
|                                                      | neurological / m     | ental status,                                            |       |            |                                                                                        |        |            |
|                                                      | genitourinary, po    | ulmonary,                                                |       |            |                                                                                        |        |            |
|                                                      | musculoskeletal,     | , integumentary                                          |       |            |                                                                                        |        |            |
|                                                      | assessments, into    | erventions, and                                          |       |            |                                                                                        |        |            |
|                                                      | professional serv    | vices provided. The note                                 |       |            |                                                                                        |        |            |
|                                                      | also failed to inc   | elude a signature with                                   |       |            |                                                                                        |        |            |
|                                                      | date. On 6/5/17.     | , the agency provided                                    |       |            |                                                                                        |        |            |
|                                                      | another visit not    | e that evidenced an                                      |       |            |                                                                                        |        |            |
|                                                      | assessment of th     | e cardiovascular,                                        |       |            |                                                                                        |        |            |
|                                                      | gastrointestinal,    | neurological / mental                                    |       |            |                                                                                        |        |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 225 of 247

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

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                              | A. BUILDING 00  B. WING                                                                                                                                                                                                               |  |                     | COMPLETED 06/05/2017                                                                                                   |    |                            |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|------------------------------------------------------------------------------------------------------------------------|----|----------------------------|
| NAME OF I                                             | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                         | -                                                                                                                                                                                                                                     |  |                     | DDRESS, CITY, STATE, ZIP CODE                                                                                          |    |                            |
| AT HOM                                                | E HEALTH SERVIC                                                                                                                                                                                                                                              | ES LLC                                                                                                                                                                                                                                |  |                     | 82ND ST STE 216<br>APOLIS, IN 46250                                                                                    |    |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                               | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                     |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΤE | (X5)<br>COMPLETION<br>DATE |
|                                                       | but failed to evic<br>interventions, an<br>provided.                                                                                                                                                                                                         | integumentary systems<br>lence a pain assessment,<br>d professional services                                                                                                                                                          |  |                     |                                                                                                                        |    |                            |
|                                                       | indicated the intereducation of g-tu- instruction, signs disease process, visit note also in- medications were with the physicia to evidence what to tube feedings, symptoms of the patient's understa provided, and an site and the spec- well as the medic |                                                                                                                                                                                                                                       |  |                     |                                                                                                                        |    |                            |
|                                                       | the interventions of g-tube feeding instruction, signs disease process, note also indicate the physician and visit note failed to educated in regar                                                                                                          | 7, the visit note indicated a provided was education gs, medication s and symptoms of and g-tube site care. The ed the spouse notified d to "see narrative." The to evidence what was rds to tube feedings, I signs / symptoms of the |  |                     |                                                                                                                        |    |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 226 of 247

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                            | (X2) MULTIPLE C A. BUILDING B. WING                                                                                               | ONSTRUCTION OO      | (X3) DATE SURVEY COMPLETED 06/05/2017                                                                                           |                      |
|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------|
| NAME OF F                                                                                                   | PROVIDER OR SUPPLIER                                                                                       |                                                                                                                                   |                     | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216                                                                             |                      |
| AT HOM                                                                                                      | E HEALTH SERVIC                                                                                            | ES LLC                                                                                                                            | INDIA               | NAPOLIS, IN 46250                                                                                                               |                      |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN                                                                                             | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                   | (X5) COMPLETION DATE |
|                                                                                                             | and an assessme the specific "care                                                                         | f the education provided,<br>nt of the g-tube site and<br>e" provided as well as the<br>gards to the patient's<br>n notification. |                     |                                                                                                                                 |                      |
|                                                                                                             | Services and Em<br>Assistant Director<br>had no further in                                                 | n relation to the above                                                                                                           |                     |                                                                                                                                 |                      |
|                                                                                                             | further informati                                                                                          | the Alternate and Employee B, had no son or documentation by ace on 6/5/17 at 3:50 p.m.                                           |                     |                                                                                                                                 |                      |
|                                                                                                             | Nursing Services The Registered I reevaluates the c                                                        | olicy titled "Skilled<br>s" C - 200, indicated "<br>Nurse Regularly<br>lients needs, and<br>necessary services "                  |                     |                                                                                                                                 |                      |
| N 0558                                                                                                      | 410 IAC 17-14-1(a                                                                                          |                                                                                                                                   |                     |                                                                                                                                 |                      |
| Bldg. 00                                                                                                    | practice in the hor licensed practical following: (F) Accept and cachiropractor, podia (oral and written). | (2)(F) For purposes of me health setting, the nurse shall do the arry out physician, dentist, atrist, or optometrist orders       |                     |                                                                                                                                 |                      |
|                                                                                                             | the agency failed                                                                                          | review and interview, I to ensure clinical staff n of care in relation to                                                         | N 0558              | Director of Nursing will in-serv<br>nurses on requirement to follo<br>Plan of Care which includes<br>frequency and duration for |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 227 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CONSTRUCTION   |         | (X3) DATE SURVEY |                                                                        |            |            |
|------------------------------------------------------|----------------------|------------------------------|---------|------------------|------------------------------------------------------------------------|------------|------------|
| AND PLAN                                             | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BU   | JILDING          | 00                                                                     | COMPL      | ETED       |
|                                                      |                      | 15K064                       | B. WING |                  |                                                                        | 06/05/     | 2017       |
|                                                      |                      |                              |         | STREET A         | ADDRESS, CITY, STATE, ZIP CODE                                         |            |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF | 8                            |         |                  | 82ND ST STE 216                                                        |            |            |
| AT HOM                                               | E HEALTH SERVIC      | CES LLC                      |         |                  | APOLIS, IN 46250                                                       |            |            |
| (X4) ID                                              | SUMMARY S            | TATEMENT OF DEFICIENCIES     |         | ID               | PROVIDER'S PLAN OF CORRECTION                                          |            | (X5)       |
| PREFIX                                               | (EACH DEFICIEN       | CY MUST BE PRECEDED BY FULL  |         | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE         | COMPLETION |
| TAG                                                  |                      | LSC IDENTIFYING INFORMATION) |         | TAG              | DEFICIENCY)                                                            |            | DATE       |
|                                                      |                      | uration of patient visits,   |         |                  | disciplines ordered by MD and                                          |            |            |
|                                                      | personal care, ar    | nd providing services        |         |                  | was tasks nurse is to provide. visit is not made, nurse will           | па         |            |
|                                                      | without a physic     | ian's order in 2 of 4        |         |                  | document reason, complete a                                            |            |            |
|                                                      | active records re    | eviewed of patients with     |         |                  | missed visit report and notify N                                       | ИD         |            |
|                                                      | skilled nursing s    | ervices in a sample of 10.   |         |                  | of missed visit. If patient requir                                     |            |            |
|                                                      | (#4 and 6)           | •                            |         |                  | a task that is not listed on the                                       |            |            |
|                                                      |                      |                              |         |                  | Plan of care, nurse will contact                                       |            |            |
|                                                      | Findings include     | <u>.</u>                     |         |                  | MD and obtain an order for the                                         |            |            |
|                                                      | i mamgs merade       | ··                           |         |                  | needed task. If LPN notes ther<br>is something needed that is no       |            |            |
|                                                      | 1 The distinct       | and for notices #4           |         |                  | on the Plan of Care, LPN will                                          | , ,        |            |
|                                                      |                      | record for patient #4,       |         |                  | contact he RN case manager                                             | or         |            |
|                                                      | · ·                  | cluded a plan of care for    |         |                  | Director of Nursing to discuss                                         |            |            |
|                                                      |                      | period of 4/24/17 to         |         |                  | patient's need before MD is                                            |            |            |
|                                                      | 6/22/17, with or     | ders for a licensed          |         |                  | contacted. (To be completed b                                          | у          |            |
|                                                      | practical nurse (    | LPN) up to 3 hours per       |         |                  | 8/25/17) Director of Nursing will be                                   |            |            |
|                                                      | day, 5 days a we     | ek to assist with personal   |         |                  | responsible to ensure orientati                                        | on         |            |
|                                                      | care, transfers, n   | nedication reminders,        |         |                  | of newly hired nurses includes                                         |            |            |
|                                                      | meal preparation     | n / setup, and light         |         |                  | training on requirement to follo                                       | w          |            |
|                                                      | housekeeping.        |                              |         |                  | Plan of Care which includes                                            |            |            |
|                                                      |                      |                              |         |                  | frequency and duration for                                             |            |            |
|                                                      | A During a           | home visit on 6/1/17 at      |         |                  | disciplines ordered by MD and was tasks nurse is to provide.           |            |            |
|                                                      | I -                  | PN was observed to           |         |                  | visit is not made, nurse will                                          | па         |            |
|                                                      |                      | d dilantin (anti-seizure     |         |                  | document reason, complete a                                            |            |            |
|                                                      | _                    |                              |         |                  | missed visit report and notify N                                       | ИD         |            |
|                                                      | ' •                  | enol and ibuprofen (used     |         |                  | of missed visit. If patient requir                                     | res        |            |
|                                                      | for mild pain an     |                              |         |                  | a task that is not listed on the                                       |            |            |
|                                                      | 11                   | 00 ml (milliliters) of       |         |                  | Plan of care, nurse will contact                                       |            |            |
|                                                      |                      | agh the patient's gastric    |         |                  | MD and obtain an order for the<br>needed task. If LPN notes ther       |            |            |
|                                                      | tube (g-tube) bet    | fore, during, and after      |         |                  | is something needed that is no                                         |            |            |
|                                                      | medication admi      | inistration. In the          |         |                  | on the Plan of Care, LPN will                                          |            |            |
|                                                      | kitchen, a piece     | of paper that was secured    |         |                  | contact he RN case manager                                             | or         |            |
|                                                      | _                    | contained a list of          |         |                  | Director of Nursing to discuss                                         |            |            |
|                                                      |                      | water flushes with times     |         |                  | patient's need before MD is                                            | <b>-</b> \ |            |
|                                                      |                      | The LPN indicated the        |         |                  | contacted. (To begin by 8/25/1                                         | ,          |            |
|                                                      |                      | metimes have the             |         |                  | Director of Nursing/designee v audit 100% of nursing                   | VIII       |            |
|                                                      | -                    |                              |         |                  | documentation weekly, until                                            |            |            |
|                                                      | medications adm      | ninistered prior to their    |         |                  |                                                                        |            |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 228 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                               | (X2) MULTIPLE CONSTRUCTION |          |                                                                                                    | (X3) DATE SURVEY |            |
|-----------|------------------------------------------------------|-------------------------------|----------------------------|----------|----------------------------------------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:        | A. BUILDING <u>00</u>      |          |                                                                                                    | COMPLETED        |            |
|           |                                                      | 15K064                        | B. WING                    |          |                                                                                                    | 06/05/           | 2017       |
|           |                                                      | l .                           |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                                                     |                  |            |
| NAME OF I | PROVIDER OR SUPPLIEF                                 | ₹                             |                            |          | 82ND ST STE 216                                                                                    |                  |            |
| ΔΤ ΗΟΜ    | E HEALTH SERVIC                                      | CESTIC                        |                            |          | APOLIS, IN 46250                                                                                   |                  |            |
|           |                                                      |                               |                            |          | 711 OE10, 114 40230                                                                                |                  |            |
| (X4) ID   |                                                      | TATEMENT OF DEFICIENCIES      |                            | ID       | PROVIDER'S PLAN OF CORRECTION                                                                      |                  | (X5)       |
| PREFIX    | `                                                    | ICY MUST BE PRECEDED BY FULL  |                            | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | ΓE               | COMPLETION |
| TAG       |                                                      | LISC IDENTIFYING INFORMATION) |                            | TAG      | · ·                                                                                                | 4-0              | DATE       |
|           |                                                      | etimes the clinical staff     |                            |          | 100% compliance is achieved, monitor compliance with follow                                        |                  |            |
|           |                                                      | dminister. The LPN            |                            |          | frequency and duration for                                                                         | mig              |            |
|           | indicated she wo                                     | ould provide g-tube site      |                            |          | disciplines ordered by MD as v                                                                     | vell             |            |
|           | care after the pat                                   | tient received a bath.        |                            |          | MD ordered plan of care and t                                                                      |                  |            |
|           |                                                      |                               |                            |          | care provided follows the MD                                                                       |                  |            |
|           | B. Review                                            | of the skilled nursing visit  |                            |          | ordered Plan of Care. Once 10                                                                      |                  |            |
|           | notes indicated t                                    | •                             |                            |          | compliance is achieved, Direct                                                                     | tor              |            |
|           | notes maioriou t                                     |                               |                            |          | of Nursing/designee will audit                                                                     |                  |            |
|           | 1 On 4                                               | ./27, 4/28, 5/2, 5/3, 5/4,    |                            |          | 25% of nursing documentation<br>monthly to monitor for continue                                    |                  |            |
|           |                                                      |                               |                            |          | compliance. (To begin by                                                                           |                  |            |
|           |                                                      | 0, 5/11, 5/15, 5/16, 5/17,    |                            |          | 8/25/17)                                                                                           |                  |            |
|           |                                                      | 5/24, 5/25, 5/30, 5/31,       |                            |          | Director of Nursing will be                                                                        |                  |            |
|           |                                                      | he visit notes indicated      |                            |          | responsible for monitoring thes                                                                    |                  |            |
|           | the skilled nurse                                    | administered tube             |                            |          | corrective actions to ensure th                                                                    |                  |            |
|           | feedings.                                            |                               |                            |          | deficiency is corrected and will                                                                   |                  |            |
|           |                                                      |                               |                            |          | not recur.                                                                                         |                  |            |
|           | 2. On 5                                              | 5/8, 5/9, 5/10, 5/11, 5/15,   |                            |          |                                                                                                    |                  |            |
|           |                                                      | 5/30, 5/31, 6/1 and           |                            |          |                                                                                                    |                  |            |
|           |                                                      | notes indicated the           |                            |          |                                                                                                    |                  |            |
|           |                                                      | ninistered water flushes.     |                            |          |                                                                                                    |                  |            |
|           | Skilled lidise adi                                   | ministered water flushes.     |                            |          |                                                                                                    |                  |            |
|           | 2.0.5                                                | 105 5/20 5/21 6/1 1           |                            |          |                                                                                                    |                  |            |
|           |                                                      | 5/25, 5/30, 5/31, 6/1 and     |                            |          |                                                                                                    |                  |            |
|           |                                                      | notes indicated the           |                            |          |                                                                                                    |                  |            |
|           | skilled nurse pro                                    | ovided g-tube site care.      |                            |          |                                                                                                    |                  |            |
|           |                                                      |                               |                            |          |                                                                                                    |                  |            |
|           | 4. On 5                                              | 5/4, 5/17, 5/25, 5/31, 6/1,   |                            |          |                                                                                                    |                  |            |
|           | and 6/4/17, the v                                    | visit notes indicated the     |                            |          |                                                                                                    |                  |            |
|           | skilled nurse wa                                     | s in the home for 4 hours     |                            |          |                                                                                                    |                  |            |
|           | and 10 hours on                                      | 5/23/17.                      |                            |          |                                                                                                    |                  |            |
|           |                                                      |                               |                            |          |                                                                                                    |                  |            |
|           | 5 Thre                                               | e (3) skilled nursing visits  |                            |          |                                                                                                    |                  |            |
|           | were made week                                       | . ,                           |                            |          |                                                                                                    |                  |            |
|           |                                                      |                               |                            |          |                                                                                                    |                  |            |
|           | _                                                    | iod and 4 skilled nursing     |                            |          |                                                                                                    |                  |            |
|           |                                                      | e week 2, 3, 5, and 6 of      |                            |          |                                                                                                    |                  |            |
|           | the certification                                    | period.                       |                            |          |                                                                                                    |                  |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 229 of 247

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                             | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                   | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION  00                                                                                                       | (X3) DATE SURVEY COMPLETED 06/05/2017 |
|--------------------------|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                      |                                                                                                                                                                                                            | 6525 E                              | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                              |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                               | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                          | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | (X5) COMPLETION DATE                  |
|                          | 5/4, 5/5, 5/8, 5/9<br>5/17, 5/18, 5/22,                                                                      | /25, 4/27, 4/28, 5/2, 5/3,<br>, 5/10, 5/11, 5/15, 5/16,<br>5/23 and 5/24/17, failed                                                                                                                        |                                     |                                                                                                                       |                                       |
|                          | plan of care in red<br>duration of visits                                                                    | es failed to follow the egards to frequency and s, providing personal providing services ian's order.                                                                                                      |                                     |                                                                                                                       |                                       |
|                          | SOC 1/30/17, ir<br>the certification<br>5/29/17, with ord<br>visit per day, up<br>times per week t           | ecord for patient #6,<br>ncluded a plan of care for<br>period of 3/31/17 to<br>ders for skilled nursing 1<br>to 2 hours per visit, 3<br>o remove and apply a<br>one day per week.                          |                                     |                                                                                                                       |                                       |
|                          | notes on 3/31, 4/4/14, 4/12, 4/19, 5/1, 5/3, 5/5, 5/8 5/19, 5/22, 5/24, visit notes failed patient's urostom | of the skilled nursing visit (3, 4/5, 4/7, 4/10, 4/12, 4/21, 4/24, 4/26, 4/28, 5/10, 5/12, 5/15, 5/17, 5/26, and 5/29/17, the to evidence that the ny wafer had been. The skilled nurse failed in of care. |                                     |                                                                                                                       |                                       |
|                          | Services and Em                                                                                              | the Director of Clinical aployee C, the Interim or of Clinical Services,                                                                                                                                   |                                     |                                                                                                                       |                                       |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 230 of 247

| STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X5)<br>COMPLETION<br>DATE |
| had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m.  4. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m.  N 0563 410 IAC 17-14-1(c)(2) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months; Based on record review and interview, the agency failed to ensure that the Registered Nurse conducted a complete skin assessment in 2 of 2 active records reviewed of a patient receiving wound treatments with a Medicare agency in a sample of 10. (#7 and 8)  Findings include:  1. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week.  A. Review of a recertification comprehensive assessment dated 4/7/17, |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 231 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                               | (X2) M                       | (X2) MULTIPLE CONSTRUCTION |                                  |                                                                     | (X3) DATE SURVEY |            |
|------------------------------------------------------|-----------------------------------------------|------------------------------|----------------------------|----------------------------------|---------------------------------------------------------------------|------------------|------------|
| AND PLAN                                             | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                              | A. BU                      | JILDING                          | 00                                                                  | COMPLETED        |            |
|                                                      |                                               | 15K064                       | B. W                       | ING                              |                                                                     | 06/05/           | 2017       |
|                                                      |                                               |                              |                            | STREET A                         | ADDRESS, CITY, STATE, ZIP CODE                                      |                  |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                          | t.                           |                            |                                  | 82ND ST STE 216                                                     |                  |            |
| AT HOM                                               | E HEALTH SERVIC                               | ES LLC                       |                            |                                  | APOLIS, IN 46250                                                    |                  |            |
| (X4) ID                                              | SUMMARY S                                     | TATEMENT OF DEFICIENCIES     |                            | ID PROVIDER'S PLAN OF CORRECTION |                                                                     |                  | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                                | CY MUST BE PRECEDED BY FULL  |                            | PREFIX                           | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG                                                  | REGULATORY OR                                 | LSC IDENTIFYING INFORMATION) |                            | TAG                              | DEFICIENCY)                                                         |                  | DATE       |
|                                                      | the "Professiona                              | l Services" narrative        |                            |                                  | document findings. If it is                                         |                  |            |
|                                                      | section indicated                             | I the patient was            |                            |                                  | documented patient has a wou                                        |                  |            |
|                                                      | receiving home                                | health services with a       |                            |                                  | then all documentation for that                                     |                  |            |
|                                                      | _                                             | y for wound treatments.      |                            |                                  | patient for that time needs to reflect the same thing. (To beg      | nin              |            |
|                                                      |                                               | rive assessment failed to    |                            |                                  | by 8/25/17)                                                         | ,                |            |
|                                                      |                                               |                              |                            |                                  | Director of Nursing/designee v                                      | vill             |            |
|                                                      |                                               | aplete skin assessment,      |                            |                                  | audit 100% of admission and                                         |                  |            |
|                                                      | _                                             | site, of the patient's       |                            |                                  | re-certifications to monitor for                                    |                  |            |
|                                                      |                                               | inical record failed to      |                            |                                  | compliance with documenting                                         |                  |            |
|                                                      |                                               | empted coordination with     |                            |                                  | complete assessment, to inclu                                       |                  |            |
|                                                      | the Medicare ago                              | ency.                        |                            |                                  | skin. Once 100% compliance i achieved 25% of admissions,            | S                |            |
|                                                      | B. A communication log dated                  |                              |                            |                                  | re-certifications will be audited                                   |                  |            |
|                                                      |                                               |                              |                            |                                  | monthly to monitor for                                              |                  |            |
|                                                      |                                               | I that the patient was       |                            |                                  | compliance. (To begin by                                            |                  |            |
|                                                      |                                               | health services with a       |                            |                                  | 8/25/17)                                                            |                  |            |
|                                                      | _                                             | are agency for the           |                            |                                  | Director of Nursing will in-serv                                    |                  |            |
|                                                      | treatment of wou                              | <u> </u>                     |                            |                                  | nurses on coordinating care w                                       |                  |            |
|                                                      | treatment of wot                              | inas.                        |                            |                                  | all medical agencies involved patient. Training will include        | with             |            |
|                                                      | C An inter                                    | view with the Director of    |                            |                                  | documenting name of agency,                                         |                  |            |
|                                                      |                                               | s on 5/31/17 at 11:00        |                            |                                  | name/title of person spoke with                                     |                  |            |
|                                                      |                                               |                              |                            |                                  | payer, discipline(s), frequency                                     |                  |            |
|                                                      |                                               | or of Clinical Services      |                            |                                  | duration and tasks to be provide                                    | ded.             |            |
|                                                      |                                               | e was not able to set up a   |                            |                                  | (To be done by 8/25/17)                                             |                  |            |
|                                                      | joint visit with the                          | ne Medicare agency, but      |                            |                                  | Director of Nursing will be responsible to ensure orientati         | on               |            |
|                                                      | did not indicate                              | which agency the patient     |                            |                                  | of newly hired nurses includes                                      |                  |            |
|                                                      | was with. The I                               | Director of Clinical         |                            |                                  | training on coordinating care w                                     |                  |            |
|                                                      | Services indicate                             | ed she did not want to       |                            |                                  | all medical agencies involved                                       |                  |            |
|                                                      | disrupt the patie                             | nt's dressing to assess the  |                            |                                  | patient. Training will include                                      |                  |            |
|                                                      | patient's skin.                               |                              |                            |                                  | documenting name of agency,                                         |                  |            |
|                                                      | patient's skin.                               |                              |                            |                                  | name/title of person spoke with                                     |                  |            |
|                                                      |                                               |                              |                            |                                  | payer, discipline(s), frequency duration and tasks to be            | ,                |            |
|                                                      | 2 71 1: 1                                     | 1.6                          |                            |                                  | provided. (To begin by 8/25/1                                       | 7)               |            |
|                                                      |                                               | ecord for patient #8,        |                            |                                  | Director of Nursing/designe                                         | -                |            |
|                                                      | •                                             | luded a plan of care for     |                            |                                  | will audit 100% of admission                                        |                  |            |
|                                                      | · ·                                           | period of 3/31/17 to         |                            |                                  | resumptions and                                                     | 113,             |            |
|                                                      | 5/29/17. The pla                              | an of care indicated the     |                            |                                  | re-certifications to monitor f                                      | or               |            |
|                                                      | patient was recei                             | iving skilled nursing and    |                            |                                  | compliance of coordinating                                          | 01               |            |
|                                                      | 1 <sup>-</sup>                                |                              | - 1                        |                                  | I somphanioe of coordinating                                        |                  |            |

| ) /       |                                       | l í                          | (X2) MULTIPLE CONSTRUCTION                   |         |                                                                                        | (X3) DATE SURVEY |            |
|-----------|---------------------------------------|------------------------------|----------------------------------------------|---------|----------------------------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                         | IDENTIFICATION NUMBER:       | A. BUILDING 00 COMPLETED  B. WING 06/05/2017 |         |                                                                                        |                  |            |
|           |                                       | 15K064                       | B. W                                         |         |                                                                                        | 06/05/           | 2017       |
| NAME OF P | ROVIDER OR SUPPLIER                   |                              |                                              |         | ADDRESS, CITY, STATE, ZIP CODE                                                         |                  |            |
|           |                                       |                              |                                              |         | 82ND ST STE 216                                                                        |                  |            |
| AT HOME   | E HEALTH SERVIC                       | ES LLC                       |                                              | INDIAN. | APOLIS, IN 46250                                                                       |                  |            |
| (X4) ID   |                                       | TATEMENT OF DEFICIENCIES     |                                              | ID      | PROVIDER'S PLAN OF CORRECTION                                                          |                  | (X5)       |
| PREFIX    | ``                                    | CY MUST BE PRECEDED BY FULL  |                                              | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE               | COMPLETION |
| TAG       |                                       | LSC IDENTIFYING INFORMATION) |                                              | TAG     | ,                                                                                      |                  | DATE       |
|           | home health aide services with a      |                              |                                              |         | care with other medical agencies, if there are any. (                                  | To               |            |
|           | Medicare agency.                      |                              |                                              |         | begin by 8/25/17)                                                                      | 10               |            |
|           | A. Review of                          | of the OASIS start of care   |                                              |         |                                                                                        |                  |            |
|           | comprehensive a                       | assessment dated 8/3/16,     |                                              |         |                                                                                        |                  |            |
|           | •                                     | l Services" narrative        |                                              |         |                                                                                        |                  |            |
|           | indicated the pat                     | ient was receiving home      |                                              |         |                                                                                        |                  |            |
|           | •                                     | times a week through a       |                                              |         |                                                                                        |                  |            |
|           |                                       | for management of            |                                              |         |                                                                                        |                  |            |
|           |                                       | to the patient's right arm   |                                              |         |                                                                                        |                  |            |
|           | and buttocks.                         |                              |                                              |         |                                                                                        |                  |            |
|           |                                       |                              |                                              |         |                                                                                        |                  |            |
|           | B. Review o                           | of the OASIS                 |                                              |         |                                                                                        |                  |            |
|           | comprehensive r                       | ecertification assessment    |                                              |         |                                                                                        |                  |            |
|           | *                                     | /30/17, the "Professional    |                                              |         |                                                                                        |                  |            |
|           |                                       | ve indicated the patient     |                                              |         |                                                                                        |                  |            |
|           |                                       | illed nursing and home       |                                              |         |                                                                                        |                  |            |
|           | _                                     | ces through a Medicare       |                                              |         |                                                                                        |                  |            |
|           |                                       | n assessments indicated      |                                              |         |                                                                                        |                  |            |
|           | the patient did no                    |                              |                                              |         |                                                                                        |                  |            |
|           | and patient and in                    | ov mound.                    |                                              |         |                                                                                        |                  |            |
|           | C The hom                             | e health aide written        |                                              |         |                                                                                        |                  |            |
|           |                                       | ons dated 3/30/17,           |                                              |         |                                                                                        |                  |            |
|           | -                                     | home health aide to          |                                              |         |                                                                                        |                  |            |
|           | inspect the patier                    |                              |                                              |         |                                                                                        |                  |            |
|           | mspeet the patien                     | it b Grossing.               |                                              |         |                                                                                        |                  |            |
|           | The clinical reco                     | ord failed to be consistent  |                                              |         |                                                                                        |                  |            |
|           |                                       | patient's wound status,      |                                              |         |                                                                                        |                  |            |
|           |                                       | e an assessment of the       |                                              |         |                                                                                        |                  |            |
|           | wound, and faile                      |                              |                                              |         |                                                                                        |                  |            |
|           | , , , , , , , , , , , , , , , , , , , |                              |                                              |         |                                                                                        |                  |            |
|           |                                       | narrative notes related      |                                              |         |                                                                                        |                  |            |
|           | to the error.                         |                              |                                              |         |                                                                                        |                  |            |
|           | 3. Employee B.                        | the Director of Clinical     |                                              |         |                                                                                        |                  |            |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | BUILDING 00                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COMPLETED                                             |  |
| 15K064 B. V                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 06/05/2017                                            |  |
| NAME OF PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                       |  |
| AT HOME HEALTH SERVICES LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6525 E 82ND ST STE 216<br>INDIANAPOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                       |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE                                                                                                                                                                                                                                                                                                                                                                                                         | (X5) COMPLETION                                       |  |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | TAG CROSS-REFERENCED TO THE APPROPRI                                                                                                                                                                                                                                                                                                                                                                                                                                       | ATE DATE                                              |  |
| Services indicated on 6/2/17 at 4:15 p.m., that the agency was having issues with their computer program and she had notified the company on the problem.  Employee B indicated in the meantime, the nursing staff was to write a communication note / narrative indicating the problem and correctly identifying the questions with the correct answers.  Employee B was not able to provide evidence of her communication with the computer software company.  N 0606  410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. | Director of Nursing/designee in-service nurses on supervisaide at least every fourteen (days in cases where patient ir receiving skilled nurse and ais services. (To be completed bild 8/25/17)  Director of Nursing will be responsible to ensure orientatof newly hired nurses include training on supervising aide a least every fourteen (14) day cases where patient is receiving skilled nurse and aide services (To begin by 8/25/17)  Director of Nursing/designee | will 08/25/2017 ing 14) s de y tion s at s in ing es. |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 234 of 247

|                    | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE  A. BUILDING  B. WING | OO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY COMPLETED 06/05/2017                                          |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
|                    | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 6525                                | T ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |
| (X4) ID PREFIX TAG | SUMMARY S (EACH DEFICIENT REGULATORY OR Findings included 1. The clinical responsible of the clinical records and some health aided clinical record, a conducted on 03 clinical record far health aide superdays.  3. The clinical record far health aide superdays.  3. The clinical record far health aide superdays.  3. The clinical record far health aide superdays.  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17  4. The clinical record far home health aide between 1/26/17 | ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  Executed for patient #2, re) 3/6/12, was reviewed. ord failed to evidence a alth aide supervisory visit to 5/3/17.  eccord for patient #3, was reviewed and for skilled nursing and e. Review of the patient's a supervisory visit was /24/17 and 5/23/17. The ailed to evidence a home revisory visit every 14  eccord for patient #5, was reviewed. The ailed to evidence a 30 day e supervisory visit to 6/2/17.  eccord for patient #6, as reviewed and included and nursing 3 times a week aide services 7 days a of the patient's clinical asory visit was conducted to the clinical record to a home health aide | ID PREFIX TAG                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)  audit 100% of aide supervisor notes weekly until 100% compliance is achieved. Once 100% compliance is achieved 25% of aide supervisory notes be audited monthly to monitor compliance. (To begin by 8/25/17)  Director of Nursing/designee vin-service nurses on requirem to supervise aide at least ever thirty (30) days in cases where patient has aide only services (To be completed by 8/25/17)  Director of Nursing will be responsible to ensure newly hourse are trained on requirem to supervise aide at least ever thirty (30) days in cases where patient has aide only services (To begin by 8/25/17)  Director of Nursing/designee valudit 100% of aide supervisor notes weekly until 100% compliance is achieved. Once 100% compliance is achieved. Once 100% compliance is achieved. 25% of aide supervisory notes be audited monthly to monitor compliance. (To begin by 8/25/17)  Director of Nursing is respons for monitoring corrective actio to this deficiency is corrected will not recur. | y  s, s will for  will ent y e .  ired ent y e .  will y f s will for  ible ns |

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION  00                                                                                              | (X3) DATE SURVEY COMPLETED 06/05/2017 |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------|
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6525                              | ET ADDRESS, CITY, STATE, ZIP CODE<br>5 E 82ND ST STE 216<br>ANAPOLIS, IN 46250                                |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) | (X5) COMPLETION DATE                  |
|                          | SOC 7/8/16, was orders for skilled health aide. The evidenced home visit on 1/2/17, 3 clinical record fa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ecord for patient #9,<br>a reviewed and included<br>I nursing and home<br>clinical record failed to<br>health aide supervisory<br>/1/17 and 4/28/17. The<br>idled to evidence a home<br>evisory visit every 14                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                   |                                                                                                               |                                       |
| N 0608<br>Bldg. 00       | findings in accordary professional stand for every patient at (1). The medical appropriate identif (2). Name of the chiropractor, podia (3). Drug, dietary orders.  (4). Signed and of contributed to by a Clinical notes shall is rendered and in (14) days.  (5). Copies of surperson responsible component of the (6). A discharge is Based on record to ensure that visiting to the contribute of the contribute of the contributed to ensure that visiting professional standard professional s | Clinical records Int past and current Ince with accepted Ince with acc | N 0608                            | Director of Nursing/designee instruct nurses to indicate on of Care the following: the corr                   | Plan                                  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | medical record in 1 of 2<br>eviewed (#1) in a sample                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | address, status of others livin the home, what tasks are to be                                                | g in                                  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 236 of 247

| STATEMEN      | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION |          |                                                                     | (X3) DATE SURVEY |                    |
|---------------|------------------------------------------------------|------------------------------|----------------------------|----------|---------------------------------------------------------------------|------------------|--------------------|
| AND PLAN      | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BUILDING <u>00</u>      |          |                                                                     | COMPLETED        |                    |
|               |                                                      | 15K064                       | B. WING                    |          |                                                                     | 06/05/2017       |                    |
|               |                                                      |                              |                            | STREET A | ADDRESS, CITY, STATE, ZIP CODE                                      |                  |                    |
| NAME OF I     | PROVIDER OR SUPPLIER                                 | 2                            |                            |          | 82ND ST STE 216                                                     |                  |                    |
| AT HOM        | E HEALTH SERVIC                                      | CESTIC                       |                            |          | APOLIS, IN 46250                                                    |                  |                    |
|               |                                                      |                              |                            |          | 7.11 02.10, 11.1 102.00                                             |                  |                    |
| (X4) ID       |                                                      | TATEMENT OF DEFICIENCIES     |                            | ID       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE  |                  | (X5)               |
| PREFIX<br>TAG | ,                                                    | CY MUST BE PRECEDED BY FULL  |                            | PREFIX   | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                      | ΓE               | COMPLETION<br>DATE |
| TAG           |                                                      | LSC IDENTIFYING INFORMATION) |                            | TAG      | provided by staff and                                               |                  | DATE               |
|               | · ·                                                  | pdate a clinical record      |                            |          | when(nursing/aide). (To be                                          |                  |                    |
|               |                                                      | ldress location of a         |                            |          | completed by 8/25/17)                                               |                  |                    |
|               |                                                      | s services in 1 out of 5     |                            |          | Director of Nursing will be                                         |                  |                    |
|               | home visits cond                                     | lucted (#2), failed to       |                            |          | responsible to ensure newly hi                                      | red              |                    |
|               | physician orders                                     | were written for prn (as     |                            |          | nurses are trained to indicate of                                   |                  |                    |
|               | needed) visits an                                    | nd that those prn skilled    |                            |          | Plan of Care the following: the                                     |                  |                    |
|               | *                                                    | ere documented in 1 out      |                            |          | correct address, status of othe                                     |                  |                    |
|               | _                                                    | ewed (#3) of patients        |                            |          | living in the home, what tasks to be provided by staff and          | ai <del>C</del>  |                    |
|               |                                                      | sing in a sample of 10;      |                            |          | when(nursing/aide). (To be be                                       | gin              |                    |
|               |                                                      | electronic medical           |                            |          | by 8/25/17)                                                         | J                |                    |
|               |                                                      |                              |                            |          | Director of Nursing/designee w                                      | vill             |                    |
|               |                                                      | d an employee as a LPN       |                            |          | audit, weekly, 100% of Plans of                                     |                  |                    |
|               |                                                      | 1 2 out of 2 records         |                            |          | Care to monitor for compliance                                      |                  |                    |
|               | · ·                                                  | d 6) of patients receiving   |                            |          | indicating the Plan of Care has<br>the following: the correct addre |                  |                    |
|               | _                                                    | ervices from Employee E      |                            |          | status of others living in the                                      | 555,             |                    |
|               | in a sample of 10                                    | 0; failed to ensure visit    |                            |          | home, what tasks are to be                                          |                  |                    |
|               | notes were comp                                      | oleted and signed / dated    |                            |          | provided by staff and                                               |                  |                    |
|               | by the clinican in                                   | n a timely manner in 1 of    |                            |          | when(nursing/aide). Once 100                                        |                  |                    |
|               | 8 active records                                     | reviewed (#4) in a           |                            |          | compliance is achieved, Direct                                      | tor              |                    |
|               | sample of 10; fai                                    | iled to ensure that the      |                            |          | of Nursing/designee will audit                                      | 4-               |                    |
|               | _                                                    | the initial plan of care     |                            |          | 25% of Plans of Care monthly monitor for compliance. (To be         |                  |                    |
|               |                                                      | imely manner in 1 out of     |                            |          | by 8/25/17)                                                         | giii             |                    |
|               |                                                      | reviewed (#5) in a           |                            |          | Administrator/designee will                                         |                  |                    |
|               |                                                      | * *                          |                            |          | ensure that if agency changes                                       |                  |                    |
|               |                                                      | d failed to evidence a       |                            |          | electronic records vendor ager                                      | псу              |                    |
|               | •                                                    | out of 8 active records      |                            |          | has copies, either paper or                                         |                  |                    |
|               | reviewed (#9) in                                     | a sample of 10.              |                            |          | electronic, of all patient record                                   |                  |                    |
|               |                                                      |                              |                            |          | before changing vendor. (To b done by 8/25/2017)                    | е                |                    |
|               | Findings include                                     | <b>:</b> :                   |                            |          | Director of Nursing/designee v                                      | vill             |                    |
|               |                                                      |                              |                            |          | ensure there is someone                                             | -                |                    |
|               | 1. The clinical r                                    | ecord for patient #1,        |                            |          | available, in office or by phone                                    | <del>)</del> ,   |                    |
|               | Start of Care (SC                                    | OC) 03/10/15, was            |                            |          | who can assist with computer                                        |                  |                    |
|               | `                                                    | 31/17. The electronic        |                            |          | issues when staff is unable to                                      |                  |                    |
|               |                                                      | ystem provided visit         |                            |          | access patient electronic recor                                     | as.              |                    |
|               |                                                      | but did not provide          |                            |          | There will be a list posted in office, in a central location,       |                  |                    |
|               |                                                      | ual visit notes. At 2:30     |                            |          | indicating who to contact and h                                     | now              |                    |
|               | access to the acti                                   | uai visit notes. At 2.30     |                            |          | in a sound of the contract and the                                  |                  |                    |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 237 of 247

| STATEMEN  | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) MULTIPLE CONSTRUCTION |           |                                                                        | (X3) DATE SURVEY |            |
|-----------|------------------------------------------------------|------------------------------|----------------------------|-----------|------------------------------------------------------------------------|------------------|------------|
| AND PLAN  | OF CORRECTION                                        | IDENTIFICATION NUMBER:       | A. BU                      | JILDING   | 00                                                                     | COMPLETED        |            |
|           |                                                      | 15K064                       | B. WI                      | NG        |                                                                        | 06/05/           | 2017       |
|           |                                                      |                              |                            | CTD FFT A | ADDRESS CITY STATE ZIR CODE                                            |                  |            |
| NAME OF F | PROVIDER OR SUPPLIER                                 | L                            |                            |           | ADDRESS, CITY, STATE, ZIP CODE                                         |                  |            |
| 4.7.1.014 |                                                      | VEO. 1.1.0                   |                            |           | 82ND ST STE 216                                                        |                  |            |
| AT HOM    | E HEALTH SERVIC                                      | ES LLC                       |                            | INDIAN    | APOLIS, IN 46250                                                       |                  |            |
| (X4) ID   | SUMMARY S                                            | TATEMENT OF DEFICIENCIES     |                            | ID        | PROVIDER'S PLAN OF CORRECTION                                          |                  | (X5)       |
| PREFIX    | (EACH DEFICIEN                                       | CY MUST BE PRECEDED BY FULL  |                            | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ΓE               | COMPLETION |
| TAG       | REGULATORY OR                                        | LSC IDENTIFYING INFORMATION) |                            | TAG       | DEFICIENCY)                                                            |                  | DATE       |
|           | p.m., Employee                                       | B, the Director of           |                            |           | to contact them. During staff                                          |                  |            |
|           | * * * *                                              | s, was requested to          |                            |           | meetings Director of                                                   |                  |            |
|           | provide home health aide visit notes.                |                              |                            |           | Nursing/designee will remind s                                         |                  |            |
|           |                                                      |                              |                            |           | of who to contact when having                                          |                  |            |
|           |                                                      |                              |                            |           | issues retrieving patient's                                            |                  |            |
|           |                                                      | 1/17 at 3:20 p.m.,           |                            |           | electronic records. This will be                                       |                  |            |
|           | Employee B was                                       | s requested again to         |                            |           | documented in the meeting notes. (To begin by 8/25/17)                 |                  |            |
|           | provide copies o                                     | f home health aide visit     |                            |           | Director of Nursing/designee v                                         | rill             |            |
|           | notes.                                               |                              |                            |           | instruct staff on proofing                                             | VIII             |            |
|           | 110.000.                                             |                              |                            |           | documentation before submitti                                          | na               |            |
|           | D 0 00/0                                             | 2/17 -4 11.50                |                            |           | to ensure signature is present.                                        |                  |            |
|           |                                                      | 2/17 at 11:50 a.m.,          |                            |           | (To be done 8/25/17)                                                   |                  |            |
|           |                                                      | provided a print out of      |                            |           | Director of Nursing will be                                            |                  |            |
|           | home health aide                                     | e visits of recorded time    |                            |           | responsible to ensure orientati                                        | on               |            |
|           | in and time out b                                    | etween 04/12/15 to           |                            |           | of newly hired staff are instruc                                       | ted              |            |
|           | 06/12/15. Emple                                      | oyee B indicated she was     |                            |           | on proofing documentation bet                                          |                  |            |
|           | _                                                    | de any information after     |                            |           | submitting to ensure signature                                         | is               |            |
|           | 06/12/17.                                            | de any information areci     |                            |           | presntt. (To begin 8/25/17)                                            |                  |            |
|           | 00/12/17.                                            |                              |                            |           | Director of Nursing/designee v                                         | VIII             |            |
|           |                                                      |                              |                            |           | audit 100% of documentation                                            |                  |            |
|           | C. On 06/05                                          | 5/17 at 9:45 a.m.,           |                            |           | weekly to ensure the dates on documentation are correct. On            |                  |            |
|           | Employee A, the                                      | e Alternate                  |                            |           | 100% compliance is achieved,                                           |                  |            |
|           | Administrator, w                                     | as requested to provide      |                            |           | Director of Nursing/designee w                                         |                  |            |
|           |                                                      | health supervisory visit     |                            |           | audit 25% of documentation                                             |                  |            |
|           | _                                                    | 00 p.m., Employee A          |                            |           | monthly to monitor for                                                 |                  |            |
|           |                                                      |                              |                            |           | compliance. (To begin by                                               |                  |            |
|           |                                                      | npany had changed            |                            |           | 8/25/17).                                                              |                  |            |
|           |                                                      | was not able to obtain       |                            |           | The nurse who signed her                                               |                  |            |
|           | the visit notes an                                   | nd would contact the         |                            |           | electronic notes as "RN" when                                          |                  |            |
|           | Administrator to                                     | see if the agency would      |                            |           | she only had an Indiana licens                                         |                  |            |
|           | pay the former s                                     | oftware company to get       |                            |           | was an oversight when putting                                          |                  |            |
|           | 1 ^ -                                                | record and obtain the        |                            |           | her credentials in the system. That has been corrected and s           | he               |            |
|           | information.                                         |                              |                            |           | is listed and signs as an "LPN.                                        |                  |            |
|           | miormanon.                                           |                              |                            |           | She is an "RN" in Illinois and h                                       |                  |            |
|           |                                                      |                              |                            |           | an "LPN" license in Indiana. Sl                                        |                  |            |
|           |                                                      | 5/17 at 3:40 p.m.,           |                            |           | is working as an LPN for the                                           | -                |            |
|           | Employee A was                                       | s only able to provide       |                            |           | agency and follows the Nurse                                           |                  |            |
|           | nursing visit reco                                   | ords 04/21, 04/23 -          |                            |           | Practice Act standards for LPN                                         | 1.               |            |
|           |                                                      | 30 - 06/17/15, 07/20 -       |                            |           | She has not functioned in the                                          |                  |            |

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                        | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                         | (X2) MULTIPLE A. BUILDING B. WING | OO OO                                                                                                              | (X3) DATE<br>COMPI<br>06/05 |                      |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------|
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                  | 6525                              | T ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                         |                             |                      |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY S<br>(EACH DEFICIEN                                                                                                                                                             | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                           |                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY | E                           | (X5) COMPLETION DATE |
| IAU                      | 07/31/15, and 08<br>Employee A ind                                                                                                                                                      | 8/18 - 08/19/15.<br>icated she kept getting an<br>not able to access the                                                                                                                                                                                                                         | TAG                               | capacity of an RN while empty this agency.                                                                         | bloyed                      | DATE                 |
|                          | SOC (start of car<br>reviewed on 6/2/                                                                                                                                                   | re) 03/06/12, was /17. The plan of care er address where services                                                                                                                                                                                                                                |                                   |                                                                                                                    |                             |                      |
|                          | a.m., was conducted aughters home been residing. It home health aide to live with the staughter and had daughter for a loremember when The plan of care accurate informatical accurate. | visit on 6/1/17 at 9:00 cted at the patient's where the patient had During this time, the e indicated the patient use son but moved in with the d been residing with the lang time and could not the patient had moved. failed to be updated with ation of the patient's ere services were to be |                                   |                                                                                                                    |                             |                      |
|                          | SOC 11/28/16, v<br>The plan of care<br>skilled nursing e<br>medication set u<br>A. On 5/31/                                                                                             | ecord for patient #3, was reviewed on 5/31/17. included orders for every 14 days for p.  /17 at 3:00 p.m., Enterim Assistant                                                                                                                                                                     |                                   |                                                                                                                    |                             |                      |
|                          | Director of Clini                                                                                                                                                                       | ical Services, indicated                                                                                                                                                                                                                                                                         |                                   |                                                                                                                    |                             |                      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 239 of 247

|                          | IT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION 00                                                                                                        | (X3) DATE SURVEY COMPLETED 06/05/2017 |      |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------|------|
|                          | PROVIDER OR SUPPLIER<br>E HEALTH SERVIC                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6525 E                                     | ADDRESS, CITY, STATE, ZIP CODE<br>E 82ND ST STE 216<br>NAPOLIS, IN 46250                                              |                                       |      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                    | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | COMPLE DATE                           | TION |
| TAG                      | she would make patient's home to due to medication before her visit. failed to evidence visit notes for the B. On 5/31/Employee C indigo to the patient's make sure the paramedication for on C. On 6/2/1 C indicated she complete 4. The clinical r 4/26/17, was revulusing visit note following:  A. A visit in | extra visits to the of fix the medication box ons not being refilled. The clinical record be physician orders and e extra visits made.  17 at 4:10 p.m., icated she was going to shome that evening and attent had his / her turn home visit on 6/1/17.  7 at 4:45 p.m., Employee did not obtain orders nor enursing visit notes.  ecord for patient #4 SOC iewed. The skilled es indicated the  ote on 5/26/17, was 17. The visit note was failed to include gastrointestinal, ental status, | TAG                                        |                                                                                                                       |                                       | E    |
|                          | •                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                            |                                                                                                                       |                                       |      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 240 of 247

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                          | X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  06/05/2017 |               |     | ETED                                                                                   |                    |      |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------|-----|----------------------------------------------------------------------------------------|--------------------|------|
|                                                                                                    |                                                                                                                          | 15K064                                                                                   | B. W          |     |                                                                                        | 06/05/             | 2017 |
| NAME OF I                                                                                          | PROVIDER OR SUPPLIEF                                                                                                     | R                                                                                        |               | 1   | ADDRESS, CITY, STATE, ZIP CODE                                                         |                    |      |
| AT HOME HEALTH SERVICES LLC                                                                        |                                                                                                                          |                                                                                          |               |     | 82ND ST STE 216<br>APOLIS, IN 46250                                                    |                    |      |
| (X4) ID                                                                                            | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION) |                                                                                          |               | ID  | PROVIDER'S PLAN OF CORRECTION                                                          | (X5)               |      |
| PREFIX<br>TAG                                                                                      |                                                                                                                          |                                                                                          | PREFIX<br>TAG |     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE COMPLETION DATE |      |
| TAG                                                                                                |                                                                                                                          | 7, the agency provided                                                                   |               | TAG | BETTELLINETY                                                                           |                    | DATE |
|                                                                                                    |                                                                                                                          | e dated 5/26/17 that                                                                     |               |     |                                                                                        |                    |      |
|                                                                                                    | evidenced an ass                                                                                                         |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | cardiovascular,                                                                                                          |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | neurological / m                                                                                                         |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | genitourinary, p                                                                                                         |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | , integumentary systems                                                                  |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | dence a pain assessment,                                                                 |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | nd professional services                                                                 |               |     |                                                                                        |                    |      |
|                                                                                                    | provided. At the                                                                                                         | e top of the visit note, it                                                              |               |     |                                                                                        |                    |      |
|                                                                                                    | is indicated that the LPN signed the visit                                                                               |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | note on 6/4/17 a                                                                                                         | nd at the bottom of the                                                                  |               |     |                                                                                        |                    |      |
|                                                                                                    | page, the note in                                                                                                        | dicated the LPN signed                                                                   |               |     |                                                                                        |                    |      |
|                                                                                                    | the visit note on                                                                                                        | 5/26/17.                                                                                 |               |     |                                                                                        |                    |      |
|                                                                                                    | C. The first                                                                                                             | maga of the shilled                                                                      |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | page of the skilled es dated 4/25, 5/2, 5/8,                                             |               |     |                                                                                        |                    |      |
|                                                                                                    | _                                                                                                                        | 5/22, 5/23, 5/25, 6/1, and                                                               |               |     |                                                                                        |                    |      |
|                                                                                                    | 6/2/17, indicated                                                                                                        |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | · ·                                                                                                                      | nployee E, a Registered                                                                  |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | st page of the visit notes                                                               |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | lly signed by Employee                                                                   |               |     |                                                                                        |                    |      |
|                                                                                                    | E, a Licensed Pr                                                                                                         |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | 1. The                                                                                                                   | Indiana Professional                                                                     |               |     |                                                                                        |                    |      |
|                                                                                                    | Licensing website was reviewed and                                                                                       |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | indicated that Er                                                                                                        | nployee E was a LPN                                                                      |               |     |                                                                                        |                    |      |
|                                                                                                    | only. The only Registered Nurses with Employee E name were licensed in                                                   |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | Illinois.                                                                                                                |                                                                                          |               |     |                                                                                        |                    |      |
|                                                                                                    | 2 77                                                                                                                     | n 1 A d 45 ·                                                                             |               |     |                                                                                        |                    |      |
|                                                                                                    |                                                                                                                          | Employee A, the Alternate                                                                |               |     |                                                                                        |                    |      |
|                                                                                                    | · ·                                                                                                                      | nd Employee B, the                                                                       |               |     |                                                                                        |                    |      |
|                                                                                                    | Director of Clini                                                                                                        | ical Services, were                                                                      |               |     |                                                                                        |                    |      |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 241 of 247

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

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                  | A. BUILDING 00  B. WING                                                                                                                                                                                                                                                                                                                       |  |                                                              | COMPLETED 06/05/2017                                                                                          |     |                            |  |  |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----|----------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                               |  | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 |                                                                                                               |     |                            |  |  |
| AT HOME HEALTH SERVICES LLC                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                               |  | 1                                                            | APOLIS, IN 46250                                                                                              |     |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                             |  | ID<br>PREFIX<br>TAG                                          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5)<br>COMPLETION<br>DATE |  |  |
| 170                                                   | intereviewed on Employee A and discrepancy was that Employee E hospital with his worked for the his / her LPN lic with the hospital 5. The clinical r 11/21/16, was re of care dated 11/evidenced that the plan of care on 1 failed to ensure the initial plan of timely manner.  6. The clinical r SOC 1/30/17, where A. Skilled r 4/12, 4/17, 4/19, indicated the note Employee E, a R visit notes were Employee E, a L 1. The Licensing websi | 6/5/17 at 3:45 p.m.  B indicated that the a computor error and worked for a local / her RN license and ome health agency under ense due to a contract  ecord for patient #5 SOC viewed. The initial plan /21/16 to 1/20/17, he physician signed the /13/17. The agency that the physician signed f care orders within a ecord for patient #6, |  | IAU                                                          |                                                                                                               |     | DATE                       |  |  |
|                                                       | only. The only l                                                                                                                                                                                                                                                                                                                                                                                                                                 | Registered Nurses with ne were licensed in                                                                                                                                                                                                                                                                                                    |  |                                                              |                                                                                                               |     |                            |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 242 of 247

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

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K064 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A. BU                                                                                                                                                                                                                                                                                                | A. BUILDING 00  B. WING |                     |                                                                                                                        | COMPLETED 06/05/2017 |                            |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                      |                         |                     | DDRESS, CITY, STATE, ZIP CODE                                                                                          |                      |                            |
| AT HOME HEALTH SERVICES LLC                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                      |                         |                     | 82ND ST STE 216<br>APOLIS, IN 46250                                                                                    |                      |                            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                    |                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΓE                   | (X5)<br>COMPLETION<br>DATE |
|                                                       | and Director of Cintereviewed on they indicated the computor error as worked for a loce RN license and whealth agency undue to a contract agency did not witruly a registered.  7. The clinical resort SOC 7/8/16, was physician orders the current certification requested on 5/3 6/2/17. The agency patient #9's physicare.  9. Employee B, Services and Empariement Assistant Director had no further in documentation in findings on 6/2/11. Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services and Employee A Administrator are further informatical resort and the services are further informatical resort and the services and the services are further informatical resort and the services are further informatical resort and the services are further informatical resort and the services | ecord for patient #9, a reviewed. A request for and the plan of care for and the plan of care for and again on an economic failed to evidence ician orders and plan of the Director of Clinical aployee C, the Interimor of Clinical Services, formation or a relation to the above 1.7 at 4:00 p.m. |                         |                     |                                                                                                                        |                      |                            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 243 of 247

| STATEMENT OF DEFICIENCIES                                |                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU                                             |        | SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |            |
|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|------------|
| AND PLAN OF CORRECTION                                   |                                                                                                                                                                                                                                 | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                    | A. BUILDING <u>00</u>                                                               |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | COMPLETED  |            |
| 15K064                                                   |                                                                                                                                                                                                                                 | B. WING 06/05/2                                                                                                                                                                                                                                                                                                                           |                                                                                     |        | 2017                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |            |            |
| NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICES LLC |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |            |            |
| (X4) ID                                                  | SUMMARY ST                                                                                                                                                                                                                      | TATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                  |                                                                                     | ID     | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                         |            | (X5)       |
| PREFIX                                                   | (EACH DEFICIENCE                                                                                                                                                                                                                | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                               |                                                                                     | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                   | ΓE         | COMPLETION |
| TAG                                                      | REGULATORY OR                                                                                                                                                                                                                   | LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                              |                                                                                     | TAG    | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |            | DATE       |
| N 0610                                                   | 410 IAC 17-15-1(a                                                                                                                                                                                                               | a)(7)                                                                                                                                                                                                                                                                                                                                     |                                                                                     |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |            |            |
| Bldg. 00                                                 | legible, clear, com<br>authenticated and<br>must include signa<br>computer entry.                                                                                                                                               | )(7) All entries must be plete, and appropriately dated. Authentication atures or a secured                                                                                                                                                                                                                                               | NO                                                                                  | (10    | Administrator/designed will                                                                                                                                                                                                                                                                                                                                                                                                                                                           |            | 00/05/0017 |
|                                                          | the agency failed<br>contents of a pati<br>retained and acce<br>reviewed in a sar                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                           | N 0                                                                                 | 610    | Administrator/designee will ensure that if agency changes electronic records vendor agency has copies, either paper or electronic, of all patient records before changing vendor. (To be done by 8/25/2017)  Director of Nursing/designee will                                                                                                                                                                                                                                        |            | 08/25/2017 |
|                                                          | Start of Care (SC reviewed on 05/3 medical record sydates and times be access to the actup.m., Employee Clinical Services provide home he  2. On 06/01/17 awas requested aghome health aide  3. On 06/02/17 aB provided a print | ecord for patient # 1, OC) 03/10/15, was 31/17. The electronic system provided visit but did not provide all visit notes. At 2:30 B, the Director of s, was requested to alth aide visit notes.  at 3:20 p.m., Employee B gain to provide copies of e visit notes.  at 11:50 a.m., Employee at 11:50 a.m., Employee mt out of home health |                                                                                     |        | ensure there is someone available, in office or by phone who can assist with computer issues when staff is unable to access patient electronic recor There will be a list posted in office, in a central location, indicating who to contact and I to contact them. During staff meetings Director of Nursing/designee will remind sof who to contact when having issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17) | ds.<br>now |            |
|                                                          | out between 04/1<br>Employee B indi                                                                                                                                                                                             | aide visits of recorded time in and time out between 04/12/15 to 06/12/15. Employee B indicated she was not able to provide any information after 06/12/17.                                                                                                                                                                               |                                                                                     |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |            |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 244 of 247

|                                                           | T OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                          | onstruction<br>00                                                                                                                                                                    | (X3) DATE SURVEY COMPLETED 06/05/2017 |  |  |  |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                      |                                       |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                  | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                               | (X5) COMPLETION DATE                  |  |  |  |
|                                                           | A, the Alternate requested to provide health supervisor 12:00 p.m., Employment and the was not able to a would contact the agency would software comparrecord and obtain 5. On 06/05/17 A was only able records 04/21, 04/06/17/15, 07/20/08/19/15. Employment and work and the contact that the agency would software comparrecord and obtain 5. On 06/05/17 A was only able records 04/21, 04/06/17/15, 07/20/08/19/15. Employment and work and the contact that the contact th | at 9:45 a.m., Employee Administrator, was vide patient #1 home ry visit records. At loyee A indicated the anged software and she obtain the visit notes and e Administrator to see if d pay the former ry to get into the clinical in the information.  at 3:40 p.m., Employee to provide nursing visit 4/23 -4/28/15 and 06/30 07/31/15, and 08/18 - oyee A indicated she error" and was not able ine health aide visit notes. |                                                                                     |                                                                                                                                                                                      |                                       |  |  |  |
| N 0612<br>Bldg. 00                                        | shall be retained for required by IC 16-services are terminagency. Policies even if the home hoperations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Original clinical records or the length of time as 39-7 after home health nated by the home health shall provide for retention nealth agency discontinues                                                                                                                                                                                                                                                                       | N 0 6 1 2                                                                           | Administrator/designes will                                                                                                                                                          | 00/05/2017                            |  |  |  |
|                                                           | the agency failed contents of a pat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | review and interview, I to ensure that all the ient's clinical record was essible in 1 of 1 record mple of 10. (#1)                                                                                                                                                                                                                                                                                                             | N 0612                                                                              | Administrator/designee will ensure that if agency changes electronic records vendor age has copies, either paper or electronic, of all patient record before changing vendor. (To be | ency<br>ds                            |  |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 245 of 247

|                                                           | NT OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE C A. BUILDING B. WING                                                 | onstruction<br>00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY COMPLETED 06/05/2017    |  |  |  |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                                  | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                    | (X5) COMPLETION DATE                     |  |  |  |
|                                                           | Start of Care (SO reviewed on 05/2 medical record s dates and times access to the act p.m., Employee Clinical Services provide home health aided as home health aided as home health aided as home health aided as on 06/02/17 B provided a primariate visits of recout between 04/Employee B indigenous provide any information of the Alternate requested to provide the supervisor 12:00 p.m., Employee Bind provide any information of the Alternate requested to provide any information of | ecord for patient # 1, DC) 03/10/15, was 31/17. The electronic ystem provided visit but did not provide ual visit notes. At 2:30 B, the Director of s, was requested to eath aide visit notes.  at 3:20 p.m., Employee B gain to provide copies of e visit notes.  at 11:50 a.m., Employee at 11:50 a.m., Employee note of home health orded time in and time 12/15 to 06/12/15. Sicated she was not able to rmation after 06/12/17.  at 9:45 a.m., Employee Administrator, was wide patient #1 home ry visit records. At ployee A indicated the anged software and she obtain the visit notes and the Administrator to see if |                                                                                     | done by 8/25/2017) Director of Nursing/designee ensure there is someone available, in office or by phor who can assist with compute issues when staff is unable to access patient electronic recording the alist posted in office, in a central location, indicating who to contact and to contact them. During staff meetings Director of Nursing/designee will remind of who to contact when havin issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17) | ne,<br>r<br>o<br>ords.<br>I how<br>staff |  |  |  |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 246 of 247

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

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

|                                                           | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K064                                                                                                                 | l í                                                                                 | JILDING                                                                | onstruction  00               | (X3) DATE<br>COMPL<br>06/05 | ETED       |
|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------|-----------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER  AT HOME HEALTH SERVICES LLC |                                                                                                                      |                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250 |                                                                        |                               |                             |            |
| (X4) ID                                                   | SUMMARY S                                                                                                            | TATEMENT OF DEFICIENCIES                                                                                                                                                 |                                                                                     | ID                                                                     | PROVIDER'S PLAN OF CORRECTION |                             | (X5)       |
| PREFIX                                                    | (EACH DEFICIEN                                                                                                       | CY MUST BE PRECEDED BY FULL                                                                                                                                              |                                                                                     | PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP |                               | ATE                         | COMPLETION |
| TAG                                                       | REGULATORY OR                                                                                                        | LSC IDENTIFYING INFORMATION)                                                                                                                                             |                                                                                     | TAG                                                                    | DEFICIENCY)                   |                             | DATE       |
|                                                           | 5. On 06/05/17<br>A was only able<br>records 04/21, 0-<br>06/17/15, 07/20<br>08/19/15. Employed<br>kept getting an " | at 3:40 p.m., Employee to provide nursing visit 4/23 -4/28/15 and 06/30 - 07/31/15, and 08/18 - oyee A indicated she error" and was not able me health aide visit notes. |                                                                                     |                                                                        |                               |                             |            |

State Form Event ID: NZKC11 Facility ID: 012383 If continuation sheet Page 247 of 247