STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
		157197	A. BUII B. WIN			12/05	/2014
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA			APOLIS, IN 46268		
(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 APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
G000000							
			G00	00000			
	This was a feder	al home health agency					
		rvey. This was a partial					
		•					
	extended survey	•					
	Survey dates: 12	2.1.14 to 12.5.14					
	Facility Number	: 005359					
	,						
	Medicaid Numb	er: 200852870					
	Survevors: Mic	chelle Weiss RN MSN					
	Public Health No						
		Koch RN Public Health					
		Rocii Kiv Public Healtii					
	Nurse Surveyor						
	Census: 65						
	Celisus. 03						
	Quality Review:	Joyce Elder, MSN,					
	BSN, RN	, ,					
	*	cember 11, 2014					
	Dec	Zemoet 11, 2014					
G000158	484.18						
		F PATIENTS, POC, MED					
	SUPER						
	Care follows a wri						
	•	eriodically reviewed by a					
		e, osteopathy, or podiatric					
	medicine.						

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

TITLE

(X6) DATE

Any defiency statement 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.

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIC	00	COMPL	ETED
		157197		LDING		12/05	/2014
		<u> </u>	B. WIN		ADDRESS CITY STATE 7ID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
		CIALISTS OF INDIANA			EPAUW BLVD STE 1041		
PEDIATE	NUKSING SPE	CIALISTS OF INDIANA		INDIAN	IAPOLIS, IN 46268		
(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 CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		al record review,	G00	00158	G 158 The Administrator and		01/22/2015
	interview, and p	olicy review, the agency			Clinical Care Manager to		
	_	care and services had			compare the 485 orders to the medications, equipment, and	i C	
	been provided in	n accordance with the			treatment modality document	ed in	
	-	rs and missed visits were			the nurse's charting to ensure		
	1 ^ *	physician in 3 out of 10			MD orders are being followed		
		-			ordered. An interim order to b		
		reviewed creating the			sent to the MD as indicated to		
	l ⁻	ct all 65 patients			correct any order discrepancie		
	receiving service	es in the agency (number			Clinical Record #2 Findings:		
	2, 5 and 8).				Administrator re-educated the		
					field staff on Clinical Record	#2	
	Findings include	e:			regarding reviewing the 485, following the MD orders and r	notify	
					the office immediately of any	ioniy	
	1 Clinical mass	rd number 2 stort of some			order discrepancies. Clinical		
		rd number 2, start of care			Record #5 Findings: The		
		ined a plan of care			Administrator re-educated the		
		he physician for a			field staff on Clinical Record #		
	certification per	iod of 9/2/2014 to			that the office must be notified	d of	
	10/31/2014 with	orders for skilled			any changes in the patient's	_	
	nursing one time	e a week for 6 weeks. The			schedule. Any changes in the	9	
	_	e VS (vital signs) to			frequency/duration to be documented and communicat	had	
		ture, Pulse, Respirations,			with the MD. Clinical Record		
	1	_			Findings: The Administrator a		
		uration every visit.			re-educated the field staff		
		uded "Patient will have			regarding following the 485 as	5	
		turation] equal to or			ordered. The Administrator		
	greater than 92%	%." The Durable Medical			re-educated the management		
	Equipment (DM	IE) and supplies listed the			nursing staff that any change		
	pulse oximeter o	on the plan of care.			visit frequency and/or duration	n	
	•				must be documented and communicated to the ordering	,	
	A. Schedul	ed visits were completed			Physician. The Administrator	•	
		ng on 9/2/14, 9/9/14,			Clinical Care Manager to	ana	
	1 -	23/14, but there was no			re-educated the field staff as		
					indicated regarding following	the	
		of an oxygen saturation			MD Plan of Care. Measures		
	on the home vis	_			taken to correct in future:		
	registered nurse	(RN) on $9/2/14$ or the			Measures taken to correct in		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPLET	ΓED
		157197	A. BUII B. WIN			12/05/20	014
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA			APOLIS, IN 46268		
(X4) ID		STATEMENT 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	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1	DATE
		cal Nurse (LPN) on the			future: The Administrator and Clinical Care Manager will aud		
	subsequent visit	S.			10% of client charts using the		
					process quarterly to ensure th		
	B. On 12/5	/14 at 10:55 AM,		the nursing staff is following the			
	employee H, the	e LPN, stated, "No, I			MD orders. The Administra		
	didn't check the	oxygen saturation			will be responsible for monitor	~	
	because there w	asn't a pulse ox			these corrective actions to entithe the deficiency is corrected		
	[oximeter] mach	nine there. I thought it			and will not recur.	-	
		asked the mother about					
	it. [The patient]	was on oxygen. I did not					
	see it on the plan						
	C	On 12/3/14 at 1:00 PM,					
		ee F, agreed there were					
		ration readings on the					
		ent documentation and					
	· ·	sure [he/she] had a pulse					
	oximeter."						
	2. Clinical reco	rd number 5, start of care					
		ed a plan of care					
	<u> </u>	he physician for the					
	_	iod 10/21/14 to 12/19/14					
	1 *	skilled nursing (SN) 4					
		11 hours days 1-5					
	_	55 hours / calendar					
		cal record failed to					
		nentation of notifying the					
		nissed skilled nursing visit					
	on 10/31/14, 11/	/14/14 and 11/17/14.					
	A.	In an interview with the					
	RN administrato	or, employee I, on 12/4/14					
	at 2:35, stated, "	It's always a challenge					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157197	A. BUI	LDING	00	COMPLI 12/05/2	
		157 197	B. WIN			12/03/	2014
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA			EPAUW BLVD STE 1041 APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	7 11 0210, 117 10200	I	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	for a company to	account for everyday					
	there, and when	the family is aware that					
the nurse was going to be absent, they							
	don't want a new	or different nurse. It is					
	our policy howe	ver, to notify the					
	physician and ke	eep documentation of that					
	missed visit."						
		ig a home visit on 12/2/14					
at 1:45 PM to patient 5 by LPN,							
employee D, the patient was observed							
	walking from the	_					
		5 or more feet to a					
		ea, to a closet, back to					
		l after that, to the kitchen.					
	_	ed some of the patients ked with the patient into					
		unch. During the time of					
		the patient was not					
	wearing ankle O	-					
	wearing ankie o	ithotics.					
	1) Clir	nical record #5 evidenced					
	· · · · · · · · · · · · · · · · · · ·	r certification period					
	•	2/19/2014 which states,					
		Orthotics to be worn at					
	all times when a	wake as tolerated."					
	2.) On 1	2/3/14 at 3:00 PM,					
	employee F, RN	, indicated the Orthotics					
	were not worn d	uring the observation and					
	stated, "They we	ere on the dresser in the					
	room. The nurse	had them off, probably,					
	because the patie	ent had taken a nap."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THINDTEAN	or colucterion	157197	A. BUI B. WIN	LDING		12/05/2014
NAME OF F	DD OLUDED OD CLIDDI IED		b. Will		DDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER				EPAUW BLVD STE 1041	
		CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	3. Clinical record	d number 8, start of care				
	10/5/14, included	d a plan of care				
	established by th					
	certification period 10/5/14 to 12/3/14					
	with orders for skilled nursing 03 hours					
	_	reeks and Medicaid SN 1				
		s per week. The clinical				
		evidence documentation				
		physician of a missed isit for 10/19/14.				
	skined nursing v	1811 101 10/19/14.				
	4. Pediatric Nurs	sing Specialists of				
		ealth Network policy				
		July 2012, titled "Skilled				
		s" states, "Skilled nursing				
	services will be	provided by a registered				
	nurse or License	d Practical / Vocational				
	Nurse under the	supervision of the				
	_	e and in accordance with				
	, ,,	oved plan of care				
		s requiring specialized				
	_	initiates appropriate				
	preventative and	rehabilitative				
	procedures."					
	5. Pediatric Nurs	sing Specialists of				
		are Network policy				
		October 2012, titled				
	· ·	entation" states, "To				
		rmance to the plan of				
		ons to the plan, and				
	interdisciplinary	involvement Services				
	not provided and	the reason for the				
	missed visits wil	l be documented and				

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

PRINTED: 01/12/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			ì '		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157197	A. BUILDING	00	COMPLETED 12/05/2014
		157 197	B. WING		12/05/2014
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE EPAUW BLVD STE 1041	
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		APOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
G000159	with the agency st diagnoses, including services and equiporation of visits, prognosis functional limitation nutritional requirer treatments, any satisfactory against injury, instead discharge or referrance appropriate items. Based on observer review, agency printerview, the against injury, instead on observer appropriate items. Based on observer review, agency printerview, the against injury interview, the against injury interview, agency printerview, and requipment, and requirement in the requirem	eveloped in consultation aff covers all pertinent ng mental status, types of oment required, frequency s, rehabilitation potential, ns, activities permitted, ments, medications and offety measures to protect ructions for timely ral, and any other ation, clinical record policy review, and staff ency failed to ensure the ained types of services, medications required for ds reviewed with skilled potential to affect all of tent 65 patients (patient 3	G000159	G 159 The Administrator and Clinical Care Manager to compare the 485 to the equipment orders for the patie. An interim order to be sent to t. MD as needed to correct any discrepancies. The DON and CCM to re-educated the field staff as indicated regarding following the MD Plan of Care. Findings for Clinical Record # The Administrator re-educated the field staff that any equipme changes noted in the patient's home must be communicated with the Clinical Manager.	he 4:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		157197		LDING		12/05/	2014
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DEDIATE		OLAL IOTO OF INDIANA			EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	care for the certi	fication period, 11/25/14			Findings for Patient #10: The		
		e durable medical			Administrator re-educated the		
		l as O2, (oxygen) and an			Clinical Manager regarding		
		,			documentation of Physician		
	LTV 950 Vent (veniliator).			Orders with regards to mixing		
					medication/fluid ratios and the	,	
	A. On 12/2	2/14 at 10:15 AM, during			amount to be administered. Findings for Patient #10: The		
	a home visit to p	patient #3, observation of			Administrator re-educated the		
	the patient failed	I to evidence oxygen and			field staff on Patient #10 that t	he I	
	_	e patient was stable and			Physician order must be follow		
		nd interactive and was on			and to document any changes		
	room air.	id interactive and was on			the medication regime as they		
	100111 a11.				happen. The Administrator al	so	
					re-educated the field staff on		
	B. The RN,	employee F, on			Patient #10 that the Clinical		
	December 3, 20	14, at 9:30 AM, indicated			Manager must be notified of a		
	that the most rec	ent plan of care had not			order changes in medication a	na	
		reflect that the ventilator			treatment regime. Measures taken to correct in future: The	<u> </u>	
		been discontinued.			Administrator and Clinical Car		
	and oxygen nad	decii discontinuca.			Manager will audit 10% of clie		
	G D II	N			charts using the PI		
		Nursing Specialists of			processquarterly to ensure that	ıt	
		are Network policy C-			the nursing staff is following th		
	660, revised 11/	12, states, "The Care			MD orders. The Administra		
	Plan/485 shall b	e reviewed, evaluated,			will be responsible for monitor	-	
	and revised (mir	nimally every 60 days and			these corrective actions to ens		
	`	l upon the the client's			that the deficiency is corrected and will not recur.	1	
	, , , , , , , , , , , , , , , , , , ,	l/or environment,			and will not recur.		
		ssessments, caregiver					
		, and the effectiveness of					
	the interventions	s in achieving progress					
	towards goals."						
	2. Patient number	er 10, start of care					
		ained a plan of care for					
		-					
		period 8/18/2014 to					
	L 10/16/2014 that	states "Miralax G	1		İ		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		157197	B. WIN			12/05/2	2014
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(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 DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
	1 20	be 5 times a day Mix 1/2					
	_ ^ ·	milliliters] of water.					
		every 3 hours with the					
		be." A separate order					
		tes, "MiraLax NA					
		apful mixed with 6 oz					
		rally daily as needed."					
		o the plan of treatment on					
	the same date reads, "Miralax 8.5 gm [gram] G Tube PRN [as necessary]. May						
	give daily as needed for constipation."						
		did not evidence the					
		ratio or the amount to be					
		plan of care is does not					
		e is to give 2-4 ml of the					
		5 times a day, or 15-20					
	mls of the mirala	ax mixture once day.					
	A The treet	ment record evidenced					
		en giving the drug each					
		er at approximately 9 AM					
	-	The medication treatment					
		tember states, "After					
		ch feeding." In October,					
		cord identifies the dose is					
		1 PM of "Miralax 1/2					
		20 ml H20 [water] q					
		G-button." The drug was					
	1 -	October. Therefore,					
		sistency with the					
	medication directions listed on the plan						
	of care.						
	B. On Dece	ember 5, 2014, at 10:00					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157197			ULTIPLE CO LDING	nstruction 00	(X3) DATE SURVEY COMPLETED 12/05/2014	
		137 197	B. WIN		Paragram and the day cons	12/03/2014	
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	ECIALISTS OF INDIANA			APOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPL	
ind	+	mployee F, indicated the		1710	·	DA.	I.L.
		ould be updated to include					
	_	at are used PRN with clear					
directions on the volume to mix and							
	administer.	to voiding to mix und					
	C Pediatri	c Nursing Specialists of					
		Care Network policy C-					
		/12, titled "Physicians					
	Orders" states,	•					
	· · · · · · · · · · · · · · · · · · ·	ist contain the name of the					
	drug, dosage, ro	oute of administration and					
		se when a nurse or					
	therapist receiv	es a verbal order from the					
	-	e will immediately record					
	the date, specifi	ic order, sign the interim					
	order form and	send it to the physician to					
	amend the plan	of care "					
		ic Nursing Specialists of					
		Care Network policy C-					
	· ·	/12, titled "Medication					
		he purpose of the policy					
	· •	documentation of the					
	_	assessment of all					
		e client is currently taking,					
		y discrepancies between					
	•	nd the physician and/or					
		and identify educational					
		or clients and caregivers.					
	_	umentation of changes in					
		regime as they happen,					
		changes needed in the plan					
	of care "						

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Event ID:

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	157197	A. BUILDING B. WING		12/05/2014
	RIC NURSING SPE	CIALISTS OF INDIANA	STREET 3500 D	ADDRESS, CITY, STATE, ZIP CODE EPAUW BLVD STE 1041 IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
G000170	Based on clinical interview, and obtailed to ensure swere in accordant for 2 our of 10 repotential to affect current 65 patient. Findings include 1. Clinical record 9/2/2014, contain established by the certification perint 10/31/2014 with nursing one time nurse was to take include temperate and Oxygen Satu Parameters include Oxygen Sat. [sat greater than 92%]	I record review, eservation, the agency killed nursing services ace with the plan of care ecords reviewed with the t all of the agency's ts (patient 2 and 5).	G000170	G 170 The Administrator and Clinical Care Manager to compare the 485 orders to the medications, equipment, and treatment modality noted in the nurse's documentation to ensithe MD orders are being follow as ordered. An interim order to be sent to the MD as indicated correct any order discrepancied On-going re-education of field staff as indicated regarding following the MD Plan of Care ordered. Findings for Clinical Record #2: The Administrator re-educated the field staff on Clinical Record 2 that any discrepancy in Physician Order must be communicated to the office. A interim order sent to MD to correct the order discrepancies. Findings for Clinical Record #5: The Administrator re-educated the field staff on Clinical Record # that all Physician Orders must reviewed and followed. The swas re-educated that for any reason that the patient's Orthowere not able to be worm it medicated.	e ure wed to did to es. as the ers the staff betics

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Event ID:

4I5W11

Facility ID: IN005359

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		157197	B. WIN			12/05/2014
NAME OF F	PROVIDER OR SUPPLIEI	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
					EPAUW BLVD STE 1041	
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN.	APOLIS, IN 46268	
(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	
TAG		*	-	TAG		
TAG	A. Schedule by skilled nursing 9/16/14, and 9/2 documentation of on the home vist registered nurse. Licensed Practic subsequent visit. B. On 12/5/2 employee H, the didn't check the because there we [oximeter] mach was strange and it. [The patient] see it on the plant. C. On 12/3/2 employee F, agroxygen saturation assessment documents." 2. During a home	(RN) on 9/2/14 or the cal Nurse (LPN) on the sal Nurse (LPN), stated, "No, I oxygen saturation asn't a pulse ox nine there. I thought it asked the mother about was on oxygen. I did not n of care." //14 at 1:00 PM, the RN, eed there were not on readings on the nursing mentation and stated, e/she] had a pulse		TAG	be documented in the nursing notes and communicated to the office. The Clinical Manager to update the MD of any noted problems in the usage of the Orthotics and an interim order obtained as indicated. Meast taken to correct in future: The Administrator and Clinical Call Manager will audit 10% of clied charts using the PI process quarterly to ensure that the nursing staff is following the Morders. The Administrator will be responsible for monitoring the corrective actions to ensure that the deficiency is corrected and will not recur.ollowing the MD orders.	DATE DATE DESCRIPTION OF THE PROPERTY OF THE
	-	by LPN, employee D, the erved walking from the				
	•	roximately 25 or more				
		n/play area, to a closet,				
		oom and after that, to the				
	Kuchen. The Li	N changed some of the				

	OF CORRECTION IDENTIFICATION NUMBER: 157197	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/05/2014
	PROVIDER OR SUPPLIER RIC NURSING SPECIALISTS OF INDIANA	3500 DI	ADDRESS, CITY, STATE, ZIP CODE EPAUW BLVD STE 1041 APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	patients clothes then walked with the patient into the kitchen for lunch. During the time of this observation, the patient was not wearing ankle Orthotics.			
	A. Clinical record #5 evidenced a plan of care for certification period 10/21/2014 to 12/19/2014 which states, "Bilateral ankle Orthotics to be worn at all times when awake as tolerated."			
	B. On 12/3/14 at 3:00 PM, employee F, RN, indicated the Orthotics were not worn during the observation and stated, "They were on the dresser in the room. The nurse had them off, probably, because the patient had taken a nap."			
	C. Pediatric Nursing Specialists of Indiana Home Health Network policy C-200, revised July 2012, titled "Skilled Nursing Services" states, "Skilled nursing services will be provided by a registered nurse or Licensed Practical / Vocational Nurse under the supervision of the Registered Nurse and in accordance with a medically approved plan of care Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative procedures."			

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

Event ID:

4I5W11

Facility ID: IN005359

If continuation sheet

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

PRINTED: 01/12/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157197		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/05/2014			
	PROVIDER OR SUPPLIER	CIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 DEPAUW BLVD STE 1041 INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
N0000000	This was a state relicensure surversure surversure surversure surversure surversure surversure surveyors. Nina Nurse Surveyor Mit Public Health Not Census: 65 Quality Review: BSN, RN Dec. 410 IAC 17-13-1(a Patient Care Rule 13 Sec. 1(a)	home health agency ey. re 12.1.14 to 12.5.14 : 005359 er: 200852870 a Koch Public Health schelle Weiss RN MSN urse Surveyor Joyce Elder, MSN, eember 11, 2014	N000000				
	and periodically red dentist, chiropract podiatrist, as follow						

State Form Event ID: 4I5W11 Facility ID: IN005359 If continuation sheet Page 13 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		157197	B. WIN	G		12/05/	2014
NAME OF I	DROVIDED OD GLIDDI IEE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			3500 D	EPAUW BLVD STE 1041		
	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(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 DEFICIENCY)	TE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	Based on clinica	· ·	N00	00522	N 522 The Director of Nursing and Clinical Care Manager to	3	01/22/2015
	interview, and p	olicy review, the agency			compare the 485 orders to the	۵.	
	failed to ensure	care and services had			medications, equipment,	•	
	been provided in accordance with the				frequency & duration of visits	and	
	physicians order	s and missed visits were			treatment modality noted in the		
		hysician in 3 out of 10			nurse's documentation to ensu		
		-			the MD orders are being follow		
	clinical records reviewed creating the potential to affect all 65 patients				as ordered. An interim order to be sent to the MD as indicated		
	_	_			correct any order discrepancie		
	receiving services in the agency (number 2, 5 and 8). Findings include:				Clinical Record #2 Findings: 1		
					Administrator educated the fie		
					staff nurse on Clinical Record	#2	
					that any noted discrepancies i	n	
					MD orders must be		
	Clinical recor	rd number 2, start of care			communicated to the office		
	9/2/2014, contain	ned a plan of care			Clinical Manager and/or Administrator. Clinical Record	4	
	established by th	ne physician for a			#5 and Clinical Record #8: The		
		od of 9/2/2014 to			Administrator re-educated the		
		orders for skilled			Clinical Care Manager that any	y	
		e a week for 6 weeks. The			change in the frequency and/o		
	_				duration of care order must be		
		e VS (vital signs) to			documented and reported to the	ne	
	_	ture, Pulse, Respirations,			MD. Clinical Record #5 Findings: The Administrator		
		uration every visit.			re-educated the field staff on		
		ided "Patient will have			Clinical Record #5 regarding		
		ruration] equal to or			following the 485. If patient is		
	greater than 92%	6." The Durable Medical			unable to wear or tolerate the		
	Equipment (DM	E) and supplies listed the			ordered Orthotics, the field nur	rse	
	pulse oximeter o	on the plan of care.			must communicate this to the		
		1			Clinical Care Manager. The Clinical Care Manager to notify	.,	
	A. Schedule	ed visits were completed			the MD of findings and an inte		
	by skilled nursing on 9/2/14, 9/9/14, 9/16/14, and 9/23/14, but there was no documentation of an oxygen saturation on the home visit records by the				order submitted as indicated.		
					On-going re-education of field		
					staff will be provided as neede	ed .	
					to ensure that the nurses are		
		•			following the 485. Measures		
	registered nurse	(RN) on $9/2/14$ or the			taken to correct in future: The		

State Form Event ID: 4I5W11 Facility ID: IN005359 If continuation sheet Page 14 of 25

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE COMPL		
		157197	A. BUI B. WIN	LDING G		12/05/		
NAME OF F	PROVIDER OR SUPPLIER		p. ,, 11.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
					EPAUW BLVD STE 1041			
		CIALISTS OF INDIANA			APOLIS, IN 46268			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	THE APPROPRIATE Y) DATE		
	Licensed Practic	al Nurse (LPN) on the			Director of Nursing and Clinic			
	subsequent visits	S.			Care Manager will audit 10% of client charts using the PI process.			
	5 0 10/5	44 . 40 == 13 =			quarterly to ensure that the			
	B. On 12/5/14 at 10:55 AM,				nursing staff is following the M orders. The Director of	ID		
	employee H, the LPN, stated, "No, I didn't check the oxygen saturation because there wasn't a pulse ox				Nursing will be responsible for			
					monitoring these corrective			
	[oximeter] machine there. I thought it was strange and asked the mother about				actions to ensure that the deficiency is corrected and wil	I		
					not recur.			
	_	was on oxygen. I did not						
	see it on the plan	of care."						
	C. On 12/3/14 at 1:00 PM,							
		ee F, agreed there were						
		ration readings on the ent documentation and						
	~	sure [he/she] had a pulse						
	oximeter."	vare [me/sme] mad a panse						
	2. Clinical recor	rd number 5, start of care						
	6/28//14, include	•						
	1	ne physician for the						
	•	od 10/21/14 to 12/19/14						
		killed nursing (SN) 4						
	*	11 hours days 1-5 55 hours / calendar						
		cal record failed to						
		entation of notifying the						
		issed skilled nursing visit						
		14/14 and 11/17/14.						
		In an interview with the						
		r, employee I, on 12/4/14						
	at 2:35, stated, "	It's always a challenge						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157197	B. WIN	IG		12/05/	2014
NAME OF F	ROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP CODE		
					EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(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
		account for everyday					
	•	the family is aware that					
	the nurse was going to be absent, they						
		or different nurse. It is					
		ver, to notify the					
		eep documentation of that					
	missed visit."						
	B. During a home visit on 12/2/14						
	at 1:45 PM to patient 5 by LPN,						
	employee D, the patient was observed						
	walking from the living room						
	* * *	5 or more feet to a					
		rea, to a closet, back to					
		d after that, to the kitchen.					
	_	ed some of the patients					
		ked with the patient into					
	the kitchen for lu	unch. During the time of					
	this observation,	the patient was not					
	wearing ankle O	orthotics.					
	1.) Clir	nical record #5 evidenced					
	-	r certification period					
	10/21/2014 to 12	2/19/2014 which states,					
	"Bilateral ankle	Orthotics to be worn at					
	all times when a	wake as tolerated."					
	2.) On 1	12/3/14 at 3:00 PM,					
	employee F, RN	, indicated the Orthotics					
	were not worn d	uring the observation and					
	stated, "They we	ere on the dresser in the					
	room. The nurse	had them off, probably,					
	because the pation	ent had taken a nap."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		157197	B. WIN	G		12/05/2014
NAME OF	PROVIDER OR SUPPLIE	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					EPAUW BLVD STE 1041	
PEDIATI	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268	
(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	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		d number 8, start of care				
	10/5/14, include	•				
	established by th					
	certification period 10/5/14 to 12/3/14					
		killed nursing 03 hours				
	per week for 9 weeks and Medicaid SN 1					
	hour visit 3 visits per week. The clinical					
		evidence documentation				
	of notifying the physician of a missed					
	skilled nursing visit for 10/19/14.					
	4. Pediatric Nursing Specialists of					
	Indiana Home H	lealth Network policy				
	C-200, revised.	July 2012, titled "Skilled				
	Nursing Service	s" states, "Skilled nursing				
	services will be	provided by a registered				
	nurse or License	ed Practical / Vocational				
	Nurse under the	supervision of the				
	Registered Nurs	e and in accordance with				
	a medically appr	oved plan of care				
	Provides service	s requiring specialized				
		l initiates appropriate				
	preventative and	• • •				
	procedures."					
	5. Pediatric Nurs	sing Specialists of				
	Indiana Home C	are Network policy				
		October 2012, titled				
	1	nentation" states, "To				
		rmance to the plan of				
		ons to the plan, and				
	•	involvement Services				
		the reason for the				
	-	If be documented and				

State Form Event ID: 4I5W11 Facility ID: IN005359 If continuation sheet Page 17 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157197		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/05/2014				
	PROVIDER OR SUPPLIER	CIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 DEPAUW BLVD STE 1041 INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	reported to the p	hysician."						
N000524	plan of care shall: (A) Be developed home health agen (B) Include all ser skilled service is b (B) Cover all perti (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 ragainst injury. (xi) Instructions referral.	in consultation with the cy staff. vices to be provided if a eing provided. nent diagnoses. llowing: s. vices and equipment and duration of visits. In potential. mitations. mitted. equirements. and treatments. measures to protect for timely discharge or dalities specifying length of						
	Based on observe review, agency printerview, the age plan of care contequipment, and a cout of 10 recornursing with the	ation, clinical record policy review, and staff gency failed to ensure the ained types of services, medications required for ds reviewed with skilled potential to affect all of gent 65 patients (patient 3	N000524	N-0524 The Administrator ar Clinical Care Manager to compare the 485 to the equipment orders for the pat An interim order to be sent to MD as needed to correct any discrepancies. The DON and CCM to re-educated the fiel- staff as indicated regarding following the MD Plan of Car	ient. to the			

State Form Event ID: 4I5W11 Facility ID: IN005359 If continuation sheet Page 18 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	LDING	00	COMPL	ETED
		157197	B. WIN			12/05/	2014
		l .	b. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			EPAUW BLVD STE 1041		
PEDIATE	DIC NI IRSING SPE	CIALISTS OF INDIANA			APOLIS, IN 46268		
I LDIAII	NO NONSING SI L	CIALISTS OF INDIANA		INDIAN			
(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
	and 10).				Findings for Clinical Record #		
					The Administrator re-educated the field staff that any equipment		
	Findings include	e:			changes noted in the patient's		
					home must be communicated		
	Clinical record	rd #3 contained a plan of			with the Clinical Manager. The	,	
	care for the certi	fication period, 11/25/14			Clinical Manager to send an		
	-1/23/15 with the durable medical				interim order to the MD		
	equipment listed as O2, (oxygen) and an				Findings for Patient #10: The		
	LTV 950 Vent (Administrator re-educated the Clinical Manager regarding		
	A. On 12/2/14 at 10:15 AM, during				documentation of Physician		
					Orders with regards to mixing		
	a home visit to patient #3, observation of				medication/fluid ratios and the		
					amount to be administered.		
	-	d to evidence oxygen and			Findings for Patient #10: The		
		e patient was stable and			Administrator re-educated the		
	alert, playing, ar	nd interactive and was on			field staff on Patient #10 that the		
	room air.				Physician order must be follow		
					and to document any changes the medication regime as they		
	B. The RN,	employee F, on			happen. The Administrator als		
	· ·	14, at 9:30 AM, indicated			re-educated the field staff on		
	· ·	ent plan of care had not			Patient #10 that the Clinical		
		reflect that the ventilator			Manager must be notified of a	•	
					order changes in and treatmer	nt	
	and oxygen nad	been discontinued.			regime. Measures taken to correct in		
	a 5 11				future: The Administrator and	,	
		Nursing Specialists of			Clinical Care Manager will auc		
		are Network policy C-			10% of client charts using the		
	660, revised 11/	12, states, "The Care			process quarterly to ensure the		
	Plan/485 shall b	e reviewed, evaluated,			the nursing staff is following th		
	and revised (mir	nimally every 60 days and			MD orders. The Administrate		
	as needed) based	d upon the the client's			will be responsible for monitoring these corrective actions to ens		
	health status and/or environment, ongoing client assessments, caregiver support systems, and the effectiveness of				that the deficiency is corrected		
					and will not recur.	•	
		s in achieving progress					
	towards goals."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157197			LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/05/	ETED	
NAME OF I			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF				EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	2. Patient number 8/18/2014, contain the certification 10/16/2014 that [gastrostomy] turn capful in 15 ml [seeding per Getter from 8/19/14 star Powder 1/2 car [ounces] fluid O An Addendum to the same date resigned aily as need the plan of care miral ax to water given daily. The specify the nurse miral ax mixture mls of the miral and A. The treat the nurse has been day in September. To record from September. To record from September at the treatment record from the specific that the nurse has been day in September. To record from September at the treatment record from September at the treatment record from the specific that the nurse has been day in September. To record from September at the treatment record from the specific that the specific that the nurse has been day in September. To record from the specific that the spec	er 10, start of care sined a plan of care for period 8/18/2014 to states, "Miralax G be 5 times a day Mix 1/2 milliliters] of water. every 3 hours with the be." A separate order tes, "MiraLax NA apful mixed with 6 oz rally daily as needed." to the plan of treatment on ads, "Miralax 8.5 gm PRN [as necessary]. May aded for constipation." did not evidence the ratio or the amount to be plan of care is does not to is to give 2-4 ml of the 5 times a day, or 15-20 ax mixture once day. ment record evidenced ten giving the drug each ter at approximately 9 AM the medication treatment tember states, "After ch feeding." In October, cord identifies the dose is 1 PM of "Miralax 1/2 20 ml H20 [water] q G-button." The drug was October. Therefore,		TAG	DEFICIENCY		DATE

State Form Event ID: 4I5W11 Facility ID: IN005359 If continuation sheet Page 20 of 25

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157197	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/05/2014
		101 181	B. WING		12/03/2014
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		DEPAUW BLVD STE 1041 NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	there is an incon	sistency with the ctions listed on the plan			
	AM, the RN, emplan of care show medications that	ember 5, 2014, at 10:00 aployee F, indicated the alld be updated to include are used PRN with clear evolume to mix and			
	Indiana Home C 635, revised 11/ Orders" states, " medications must drug, dosage, rou directions for use therapist receive physician he/she the date, specific	st contain the name of the ute of administration and e when a nurse or s a verbal order from the will immediately record c order, sign the interimment it to the physician to			
	Indiana Home C 700, revised 11/ Profile" states the is, "To provide comprehensive a medications the and identify any client profile and	e Nursing Specialists of are Network policy C-12, titled "Medication e purpose of the policy locumentation of the assessment of all client is currently taking, discrepancies between the physician and/or and identify educational			

State Form Event ID: 4I5W11 Facility ID: IN005359 If continuation sheet Page 21 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		157197	B. WING	<u> </u>		12/05/	2014
	ROVIDER OR SUPPLIER	CIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 DEPAUW BLVD STE 1041 INDIANAPOLIS, IN 46268				
(X4) ID	SUMMARY S	FATEMENT 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 APPROPRIATE OF T	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N000537	To provide docu the medication re and to support ch of care " 410 IAC 17-14-1(a Scope of Services	The home health agency					
	registered nurse of nurse in accordance as follows: Based on clinical interview, and of failed to ensure seems were in accordant for 2 our of 10 repotential to affect current 65 patient. Findings include 1. Clinical record 9/2/2014, containestablished by the certification peri 10/31/2014 with nursing one time nurse was to taken	r a licensed practical ce with the medical plan of a record review, oservation, the agency skilled nursing services are with the plan of care ecords reviewed with the et all of the agency's ats (patient 2 and 5).	N00	0537	N 537 The Administrator and Clinical Care Manager to compare the 485 orders to the medications, equipment, and treatment modality noted in the nurse's documentation to ensuthe MD orders are being follow as ordered. An interim order to be sent to the MD as indicated correct any order discrepancies. On-going re-education of field staff as indicated regarding following the MD Plan of Care as ordered Findings for Clinical Record #2 The Administrator re-educated the field staff on Clinical Record that any discrepancy in Physic Orders must be communicated the office. A interim order sent the MD to correct the order discrepancies.	e ure ved o I to he 2: I rd 2 cian d to	01/22/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		157197	B. WIN	G		12/05/	2014
NAME OF A	DROLUBER OR GURRU IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	C		3500 DI	EPAUW BLVD STE 1041		
	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(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' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· ·	_	DATE
		uration every visit.			Findings for Clinical Record #5		
	Parameters inclu	ided "Patient will have			The Administrator re-educated the field staff on Clinical Recor		
	Oxygen Sat. [sat	turation] equal to or			5 that all Physician Orders mu		
	greater than 92%." The Durable Medical Equipment (DME) and supplies listed the pulse oximeter on the plan of care. A. Scheduled visits were completed by skilled nursing on 9/2/14, 9/9/14, 9/16/14, and 9/23/14, but there was no documentation of an oxygen saturation on the home visit records by the registered nurse (RN) on 9/2/14 or the				be reviewed and followed. Th		
					staff was re-educated that for		
					reason that the patient's Ortho		
					were not able to be worm it m	ust	
					be documented in the nursing notes and communicated to the	0	
					office. The Clinical Manager to		
					update the MD of any noted	-	
					problems in the usage of the		
					Orthotics and an interim order		
					obtained as		
					indicated.		
		cal Nurse (LPN) on the			Measures taken to correct in future:The Administrator and		
	subsequent visit	S.			Clinical Care Manager will auc	lit	
					10% of client charts using the		
	B. On 12/5/	/14 at 10:55 AM,			process quarterly to ensure the		
	employee H, the	LPN, stated, "No, I			the nursing staff is following th	е	
	didn't check the	oxygen saturation			MD orders.		
	because there wa	asn't a pulse ox			The		
	[oximeter] mach	ine there. I thought it			Administrator will be responsib	ole	
	was strange and	asked the mother about			for monitoring these corrective	:	
	it. [The patient]	was on oxygen. I did not			actions to ensure that the		
	see it on the plan	7.0			deficiency is corrected and will not recur.	I	
	·				Hot recur.		
	C. On 12/3/	/14 at 1:00 PM, the RN,					
		eed there were not					
		on readings on the nursing					
	, , ,	imentation and stated,					
		e/she] had a pulse					
	oximeter."	arsing had a puise					
	oximeter.						
	2 During a hom	e visit on 12/2/14 at 1:45					
	1	by LPN, employee D, the					
	1 W to patient 3	by En in, employee D, the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		157197	B. WIN	G		12/05/	/2014
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DEDIATE		OLAL IOTO OF INDIANIA			EPAUW BLVD STE 1041		
PEDIATE	RIC NURSING SPE	CIALISTS OF INDIANA		INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		•		TAG	BEFFEERET		DATE
	-	rved walking from the roximately 25 or more					
		_					
	feet to a bedroom/play area, to a closet, back to the bedroom and after that, to the						
		·					
		'N changed some of the					
	-	then walked with the					
		titchen for lunch. During					
		observation, the patient					
	was not wearing	ankle Orthotics.					
	A. Clinical	record #5 evidenced a					
	plan of care for certification period						
	10/21/2014 to 12/19/2014 which states,						
		Orthotics to be worn at					
		wake as tolerated."					
		.,					
	B. On 12/3/2	14 at 3:00 PM, employee					
	F, RN, indicated	the Orthotics were not					
	worn during the	observation and stated,					
	"They were on the	he dresser in the room.					
	The nurse had th	em off, probably,					
	because the patie	ent had taken a nap."					
	C Dadiation	Namaina Chaoialista af					
		Nursing Specialists of					
		ealth Network policy C-					
		y 2012, titled "Skilled					
		s" states, "Skilled nursing					
		provided by a registered d Practical / Vocational					
		supervision of the					
	_	e and in accordance with					
		oved plan of care					
		s requiring specialized					
	nursing skill and	initiates appropriate					

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157197	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 12/05/2014	
NAME OF PROVIDER OR SUPPLIER PEDIATRIC NURSING SPECIALISTS OF INDIANA			3500 DEPAUW BLVD STE 1041 INDIANAPOLIS, IN 46268			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG			TAG	DEFICIENCY)		DATE
	preventative and procedures."	l rehabilitative				

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