STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       00       COMPLETED         B. WING       09/14/2015			ETED		
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	03/14/	2010
(X4) ID PREFIX TAG	SUMMARY ST (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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
G 0000							
Bldg. 00	Complaint invest Complaint #: IN Substantiated: Re cited.  Survey dates: 09 Facility number Medicaid Vendo Census: 74 Clinical records: RN2U, Inc. is pri its own training a evaluation progra years beginning September 14, 20 of compliance w Participation 42 Rights, 484.14 O	reviewed 4 ecluded from providing and competency am for a period of 2 September 14, 2015, to 2017, for being found out ith the Conditions of CFR 484.10 Patient organization, Services & 484.32 Therapy Services,	G 0	000			

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

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.

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDE	PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER: 57653	A. BUILDING B. WING	00	COMPLETED 09/14/2015
NAME OF F	PROVIDER OR SUPPLIER		STREE 635 S MOC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	EMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
G 0100					
Bldg. 00	care that was not further for 1 of 4 record revand failed to ensure family caregivers wadvance of the physicand the services that would not be provided for the formulative effective.  The cumulative effective for 1 of 1 records for 1 of 1 re	ensure that the egivers concern / stigated in regards to rnished by the agency viewed (See G 107) that the patient / tere informed in sician ordered services t would and / or ded prior to the start cord reviewed (See G ect of this systemic the agency being out the Condition of	G 0100	G100  1. Administrator/designee will complete a patient complain t form when receiving a complain (On-going)  2. All complaint forms will be give to Administrator sameday to revie contact person(s) making complain document conversation andsign/date form. (On-going)  3. Patient records requested to be mailed will be mailedcertified mai return receipt requested. (On-going)  4. DON/designee will notify patient/family same day it isdetermined agency cannot provia discipline. (On-going)  5. DON/designee will notify MD same day it is determined agencycannot provide a discipline (On-going)  6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and thall ordered disciplines are schedul (On-going)	n ew, nt,  I I I I I I I I I I I I I I I I I I
G 0107 Bldg. 00	by a patient or the pa	igate complaints made tient's family or eatment or care that is			

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 2 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		157653	B. W	B. WING 09/14/201			2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	STATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(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
		the patient's property by					
		services on behalf of the					
	HHA, and must do	omplaint and the resolution					
	of the complaint.	omplaint and the resolution					
	•	review and interview,	G 0	107	1. Administrator/designee will		10/16/2015
		d to ensure that the			complete a patient complaintform		
		caregivers concern /			when receiving a complaint.		
		envestigated in regards to			(On-going)		
		t furnished by the agency			2. All complaint forms will be given		
		reviewed. (#16)			to Administrator sameday to review contact person(s) making complaint		
	101 1 01 4 100014	Teviewed. (#10)			document conversation	,	
	Findings in deal				andsign/date form. (On-going)		
	Findings include	ed:			3. Patient records requested to be		
	1 01: 1	1 1 (000//			mailed will be mailedcertified mail		
		rd number 16 SOC (start			return receipt requested. (On-going	)	
	· ·	5, included a plan of care			4. DON/designee will notify		
		ne physician for the			patient/family same day it		
	certification peri	iod of 03/19/15 to			isdetermined agency cannot provide	9	
	05/17/15 and 05/	/17/15 to 07/16/15.			a discipline. (On-going)		
					5. DON/designee will notify MD		
	2. The Adminis	trator was interviewed on			same day it is determinedagency cannot provide a discipline.		
	09/14/15 at 2:15	PM. The Administrator			(On-going)		
		nd no complaints and			6. DON/designee will review all		
		the previous survey on			admissions to ensure agencycan		
	_	Administrator stated she			provide ordered disciplines and that	t	
		nily member request			all ordered disciplines are scheduled	d.	
	_	•			(On-going)		
		and the medical records			7. When agency uses a staffing		
		he requestor for patient			agency to cover a		
	#16.				disciplineDON/designee will tract al	I	
					communications with the staffing		
	3. A phone inter	rview with the			agency to ensurethere is timely		
	complainant on	09/14/15 at 2:40 PM,			follow up. (On-going)		
	stated that he / sl	he had been trying to			8. When a staffing agency is used,		
		Administrator in regards			DON/designee will contactstaffing agency daily, Mon-Fri, for		
	_	therapy services and			coordination of care. All contact wil	ı	
	io lack of specci	i merapy services and	- 1		Loorumation of care. All contact will	ı	

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 3 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  157653	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	COMPLETED 09/14/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	CCTION (X5)  WILD BE PROPRIATE  COMPLETION DATE			
	requested speech therapy records. The complainant stated he / she kept getting told that the Administrator was in a meeting or was busy. The Administrator had never returned his / her phone call. The complainant stated he / she had never received the medical records.	bedocumented in the appropatient's chart. (On-going)  9. If patient/caregiver declin therapy services, DON/design contact patient/family no lat next business day toconfirm declined therapy. Conversat be documented in appropriate patient's chart. (On-going)  10. DON/designee will in-serprofessional on requirement contact all disciplines involve patient's care and document of person spoke with along wand time. (On-going)  11. DON/designee will in-serptate in case confermal confermal contact all disciplines involved confermal conferm	es nee will ter than they ion will  vice tto ed in t name vith date  vice y MD of on and  re all t's care			
G 0108 Bldg. 00	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.  The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.  The HHA must advise the patient in advance of any change in the plan of care before the change is made.					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 4 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETI			
		157653	B. WING 09/14/2015			09/14/2015	
		l .		STREET	ADDRESS, CITY, STATE, ZIP CODE		$\dashv$
NAME OF I	PROVIDER OR SUPPLIEF	R			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
				MOOK			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	DATE	
	Based on record	review and interview,	G 0	108	1. Administrator/designee will	10/16/2015	5
	the agency failed	d to ensure that the			complete a patient complaintform		
	patient / family o	caregivers were informed			when receiving a complaint.		
	1 ^	e physician ordered			(On-going)		
		services that would and /			2. All complaint forms will be given		
					to Administrator sameday to review		
		provided in relation to			contact person(s) making complaint	,	
		prior to the start of care			document conversation		
	for 1 of 1 record	reviewed.			andsign/date form. (On-going)		
					3. Patient records requested to be		
	Findings included:				mailed will be mailedcertified mail		
					return receipt requested. (On-going	)	
	1 Clinical record number 16 SOC (start				4. DON/designee will notify		
	1. Clinical record number 16 SOC (start				patient/family same day it		
	· · · · · · · · · · · · · · · · · · ·	5, included a plan of care			isdetermined agency cannot provide	9	
	established by the	ne physician for the			a discipline. (On-going)		
	certification peri	od of 03/19/15 to			5. DON/designee will notify MD		
	05/17/15 and 05/	/18/15 to 07/16/15 with			same day it is determinedagency		
	orders for skilled	d nursing, home health			cannot provide a discipline.		
		nd occupational therapy.			(On-going) 6. DON/designee will review all		
	arac, physical an	ia occupational incrupy.			admissions to ensure agencycan		
	A 1' 1	c			provide ordered disciplines and that		
		rge summary from a			all ordered disciplines are scheduled		
		acility dated 03/17/15,			(On-going)		
	indicated the pat	tient had a past medical			7. When agency uses a staffing		
	history of aspira	tion pneumonia and			agency to cover a		
	dysphagia. The	physician's assessment			disciplineDON/designee will tract al		
	1	eumonia was resolved			communications with the staffing		
	but remains high				agency to ensurethere is timely		
	1	*			follow up. (On-going)		
	secondary to dys				8. When a staffing agency is used,		
	_	echanical soft diet with			DON/designee will contactstaffing		
	nectar thickened	liquids, and for patient /			agency daily, Mon-Fri, for		
	caregiver to refe	r to speech therapist with			coordination of care. All contact wil	ı	
	_	n on nectar thickened			bedocumented in the appropriate		
		nmary indicated the			patient's chart. (On-going)		
	_	•			9. If patient/caregiver declines		
	-	e discharged home with			therapy services,DON/designee will		
	speech therapy.				contact patient/family no later than		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		157653	B. W	B. WING 09/14/2015			2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			STATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID			(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 APPROPRIAT DEFICIENCY)			DATE
			+		next business day toconfirm they		
	1. 4				declined therapy. Conversation will		
		prescription dated			be documented in		
		ted the patient was to be			appropriatepatient's chart.		
	discharged home	e with speech therapy			(On-going)		
	services.				10. DON/designee will in-service		
					professional on requirementto		
	2. The Adminis	trator was interviewed on			contact all disciplines involved in		
	09/14/15 at 11:4				patient's care and document name		
		ated she vaguely			ofperson spoke with along with date	e	
		0 ,			and time. (On-going)		
	remembered the patient and proceeded to				11. DON/designee will in-service		
	review the patient's record. The				staff on requirement tonotify MD of	f	
		ated she had performed			changes in patient's condition and		
	the patient's adm				document in patient's chart.		
	Administrator w	as not able to answer nor			(On-going)		
	explain why spe	ech therapy was not			12. DON/designee will ensure all		
	involved in the p	patient's case when it was			disciplines involved inpatient's care will participate in case conference.		
	ordered by the p	hysician at discharge.			(On-going)		
		or stated the case			(On going)		
		ed in the patient's case					
	_	agency. During this					
	i i	istrator emailed and					
		cted therapy company					
		es for the coordinator to					
	return her phone	e call.					
	3. On 09/14/15	at 1:53 PM, the					
	Administrator ha	ad a return call from the					
	contracted therai	py company. The					
	Administrator ha						
		the contracted therapy					
		ted that a speech therapist					
		et with the spouse in July					
		was declined due to the					
	patient was "too	far gone." The					

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015		
NAME O	F PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	ATE	(X5) COMPLETION DATE	
	did not go out to that assessment. Administrator st who the speech communication provided by Emaide / office wor Employee N wro of therapy comptherapy], ST had times with no re [doctor] notified interviewed at the did not remember therapist was an the speech theraphysician office day and time the the physician.  4. The complain 09/14/15 at 2:40 stated that the pacaregivers were the patient would therapy. The constaff would notified informed the off difficulty with standing caregivers.	told upon admission that d be getting speech mplainant stated that the fy the office often and ice of the patient's wallowing. The ed that they (patient and s) were not aware that not getting speech therapy						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 7 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL		
		157653	B. WI	ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	DDRESS, CITY, STATE, ZIP CODE		
			635 S STATE RD 67				
RN2U IN	C			MOORE	ESVILLE, IN 46158		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY 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)	ATE	DATE
	themselves as sp	peech therapists. The					
	complainant stat	ed no one had called and					
	left messages no	or was any speech therapy					
	services had bee	n declined. The					
	complainant ind	icated how he / she					
		was by a therapist that					
		e and was discussing					
	1 1 1	The complainant stated					
		gotten so weak that he /					
	she was now in a skilled nursing facility						
	receiving speech	therapy.					
	5 Upon returni	ng inside the agency at					
	-	Iministrator stated that					
	-	pist was not provided by					
	the said therapy						
		note dated 03/26/15 that					
	Employee N had	l provided / indicated, but					
	the speech thera	pist was provided					
	through another	therapy company.					
	C A 1-4-1	-1: (141-1-011)					
	Admission Proc	oolicy titled Client					
		eria are standards by					
		an be deemed appropriate					
		These standards include					
		s capable of providing the					
	1	ervice at the level of					
	intensity the clie	ent's condition requires					
	<u> </u>	d care must conform with					
	current profession	onal standards of practice					
	•	e discipline and should					
		nd necessary to the					
	treatment of a m	edical disorder					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 8 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING  B. WING	00	COMPLETED 09/14/2015	
NAME OF F	PROVIDER OR SUPPLIER	635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	Agency will not admit client or continue to provide services in the following situations Scope and complexity of needs cannot be met by agency, Skills and suitability of agency personnel are not adequate to meet client needs The admission professional will verify all the information on the Intake Form with the client / caregiver Review the plan for services, treatment, and care with the client / caregiver and obtain input when possible Upon acceptance and admission of a client, the admitting Registered Nurse / Therapist will assign the individual to the appropriately skilled professional If the agency cannot fulfill the required health care need, a referral will be made to the other appropriate community resources and referral source will be notified "				
G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION				
	(A) Based on record review and interview, the Administrator failed to ensure that the patient / family caregivers concern / grievance was investigated in regards to care that was not furnished by the agency for 1 of 4 record reviewed. (B) failed to ensure that the patient / family caregivers were informed in advance of the physician ordered services and the services that would be and / or would not	G 0122	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation and sign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail		

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 9 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  157653	A. BUILDING 00  B. WING	COMPLETED 09/14/2015			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE COMPLETION OPRIATE DATE			
	be provided prior to the start of care for 1 of 1 record reviewed. (C) failed to ensure the clinical staff efforts were coordinated effectively with the physician and contracted therapy agency that were furnishing services for 1 of 4 records reviewed of patients receiving therapy services (See G 133); failed to ensure their efforts were coordinated effectively with the physician and contracted therapy agency that were furnishing services for 1 of 4 records reviewed of patients receiving therapy services (See G 143); and failed to ensure their efforts were coordinated and documented effectively with the physician and contracted therapy agency that were furnishing services for 1 of 4 records reviewed of patients receiving services (See G 144).  The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, Services, & Administration.	return receipt requested. (On- 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify Misame day it is determinedagen cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencyce provide ordered disciplines are sche (On-going) 7. When agency uses a staffing agency to cover a disciplineDON/designee will tromunications with the staff agency to ensurethere is timel follow up. (On-going) 8. When a staffing agency is us DON/designee will contactstaf agency daily, Mon-Fri, for coordination of care. All contacts bedocumented in the appropripatient's chart. (On-going) 9. If patient/caregiver declines therapy services, DON/designee contact patient/family no later next business day toconfirm the declined therapy. Conversation be documented in appropriate patient's chart. (On-going) 10. DON/designee will in-service professional on requirement to contact all disciplines involved patient's care and document in ofperson spoke with along with and time. (On-going)	rovide D cy I an d that duled.  act all ing y ed, fing ct will inte e will than ley n will ce in ame			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		157653	B. WI	NG		09/14/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
RN2U INC	?			635 S STATE RD 67 MOORESVILLE, IN 46158			
					1000		
(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	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFY ING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
					11. DON/designee will in-service		
					staff on requirement tonotify MD of		
					changes in patient's condition and		
					document in patient's chart. (On-going)		
					12. DON/designee will ensure all		
					disciplines involved inpatient's care		
					will participate in case conference.		
					(On-going)		
					, , ,		
G 0133	484.14(c)						
	ADMINISTRATOR						
Bldg. 00		who may also be the					
		cian or registered nurse ragraph (d) of this section,					
		ects the agency's ongoing					
	•	ns ongoing liaison among					
	the governing bod						
	professional perso	onnel, and the staff.					
	A. Based on rec	ord review and	G 0	133	1. Administrator/designee will		10/16/2015
	interview, the Ac	dministrator failed to			complete a patient complaintform		
	ensure that the pa	atient / family caregivers			when receiving a complaint.		
	•	nce was investigated in			(On-going)		
	•	nat was not furnished by			2. All complaint forms will be given		
	•	•			to Administrator sameday to review		
	• •	of 4 record reviewed.			contact person(s) making complaint	,	
	(#16)				document conversation and sign/dateform. (On-going)		
					3. Patient records requested to be		
	Findings include	d:			mailed will be mailedcertified mail		
					return receipt requested. (On-going	)	
	1A. Clinical rec	ord number 16 SOC			4. DON/designee will notify	,	
	(start of care) 03	/19/15, included a plan			patient/family same day it		
	` ,	ed by the physician for			isdetermined agency cannot provide	9	
		period of 03/19/15 to			a discipline. (On-going)		
	•	/17/15 to 07/16/15.			5. DON/designee will notify MD		
	55/17/15 and 05/	1,,10 to 0,,10,10.			same day it is determinedagency		
	2 A Th - A J	istrator vias intoi			cannot provide a discipline.		
		istrator was interviewed			(On-going)		
	on 09/14/15 at 2:	115 PM. The			6. DON/designee will review all		

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 11 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		157653	B. W	B. WING 09/14/2015			15
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
			_				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		ated she has had no			admissions to ensure agencycan		
		grievances since the			provide ordered disciplines and that all ordered disciplines are scheduled		
	previous survey	on 08/04/15. The			(On-going)	۱.	
	Administrator st	ated she had only one			7. When agency uses a staffing		
	family member	request medical records			agency to cover a		
	and the medical	records was mailed to			disciplineDON/designee will tract all	1	
	the requestor for	patient #16.			communications with the staffing		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1			agency to ensurethere is timely		
	3A. A phone in	terview with the			follow up. (On-going)		
	_	09/14/15 at 2:40 PM,			8. When a staffing agency is used,		
	•				DON/designee will contactstaffing		
	stated that he / she had been trying to				agency daily, Mon-Fri, for		
	_	Administrator in regards			coordination of care. All contact will		
	_	n therapy services and			bedocumented in the appropriate		
	requested speecl	n therapy records. The			patient's chart. (On-going)		
	complainant stat	ted he / she kept getting			9. If patient/caregiver declines		
	told that the Adr	ninistrator was in a			therapy services, DON/designee will contact patient/family no later than		
	meeting or was 1	busy. The Administrator			next business day toconfirm they		
	_	ed his / her phone call.			declined therapy. Conversation will		
		t stated he / she had			be documented in		
	•	he medical records.			appropriatepatient's chart.		
	never received the	ne medicai records.			(On-going)		
	D D				10. DON/designee will in-service		
	B. Based on rec				professional on requirementto		
	•	dministrator failed to			contact all disciplines involved in		
	_	atient / family caregivers			patient's care and document name		
	were informed in	n advance of the			ofperson spoke with along with date	2	
	physician ordere	ed services and the			and time. (On-going)		
	services that wo	uld be and / or would not			11. DON/designee will in-service	.	
	be provided prior	or to the start of care for 1			staff on requirement tonotify MD of		
	of 1 record revie				changes in patient's condition and document in patient's chart.		
					(On-going)		
	Findings include	sq.			12. DON/designee will ensure all		
	1 manigs meiude	vu.			disciplines involved inpatient's care		
	1D Clinical	and number 16 COC			will participate in case conference.		
		ord number 16 SOC			(On-going)		
	(start of care) 03/19/15, included a plan						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 12 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	IULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. W	ING		09/14/	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					TATE RD 67		
RN2U IN	C			MOORE	ESVILLE, IN 46158		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
		ed by the physician for					
		period of 03/19/15 to					
	05/17/15 and 05	/18/15 to 07/16/15, with					
	orders for skilled	d nursing, home health					
	aide, physical an	d occupational therapy.					
		rge summary from a					
	_	acility dated 03/17/15,					
	_	ient had a past medical					
		tion pneumonia and					
		physician's assessment eumonia was resolved					
	but remains high						
	secondary to dys	•					
		echanical soft diet with					
	_	liquids, and for patient /					
		r to speech therapist with					
	_	n on nectar thickened					
	liquids. The sun	nmary indicated the					
	patient was to be	e discharged home with					
	speech therapy.						
	_	prescription dated					
		ted the patient was to be					
		e with speech therapy					
	services.						
	2B The Admin	istrator was interviewed					
	on 09/14/15 at 1						
	Administrator st						
		patient and proceeded to					
	review the patien	-					
	_	ated she had performed					
	the patient's adm	_					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 13 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  157653		onstruction 00	(X3) DATE SURVEY  COMPLETED  09/14/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	Administrator was not able to answer nor explain why speech therapy was not involved in the patient's case when it was ordered by the physician at discharge. The Administrator stated the case manager involved in the patient's case retired from the agency. During this time, the Administrator emailed and called the contracted therapy company and left messages for the coordinator to return her phone call.  3B. On 09/14/15 at 1:53 PM, the Administrator had a return call from the contracted therapy company. The Administrator had stated that the coordinator from the contracted therapy company indicated that a speech therapist had made contact with the spouse in July but the services was declined due to the patient was "too far gone." The Administrator stated the speech therapist did not go out to see the patient to make that assessment / judgment and the Administrator stated she did not know who the speech therapist was. A communication note dated 03/26/15, was provided by Employee N, a home health aide / office worker, during this time. Employee N wrote "According to [Name of therapy company] ST [speech therapy], ST had called numberous [sic] times with no return call to ST. Dr. [doctor] notified." Employee N was					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 14 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		r í	ILDING	NSTRUCTION 00	(X3) DATE COMPL <b>09/14</b> /	ETED			
NAME OF P	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE		
IAU	interviewed at the did not remember therapist was and the speech therapy physician office day and time the the physician.  4B. The complate 09/14/15 at 2:40 stated that the paragivers were the patient would therapy. The constaff would notify informed the off difficulty with sweep complainant state family caregiver the patient was refor some of the state that the patient was refor some of the state that the patient was refor some of the state that the patient was refor some of the state that the patient was refor some of the state that the patient was refor some of the state that the patient was refored the state that the patient was refored the state that the patient had been complainant indicated the patient had guite the patient had gui	is time and stated she er who the speech d she did not know who bist spoke with at the and did not know what speech therapist notified  inant was contacted on PM. The complainant attent and family told upon admission that d be getting speech inplainant stated that the by the office often and dice of the patient's wallowing. The ed that they (patient and es) were not aware that not getting speech therapy staff portrayed eech therapists. The ed no one had called and r was any speech therapy in declined. The dicated how he / she was by a therapist that e and was discussing The complainant stated often so weak that he / in skilled nursing facility		IAU			DATE		
	5B. Upon return	ing inside the agency at							

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 15 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

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	COMPLETED	
		157653	B. W	ING			09/14/2015	
NAME OF F			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	C		635 S S	STATE RD 67			
RN2U IN					ESVILLE, IN 46158			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	ΓE	COMPLETION DATE	
TAG		Iministrator stated that	+	TAG			DATE	
	· ·							
	the speech therapist was not provided by the said therapy company on the							
		note dated 03/26/15 that						
		l provided / indicated, but						
		pist was provided						
		therapy company.						
	unough another	merapy company.						
	6B. An undated	policy titled Client						
	Admission Proce	ess indicated,						
	"Admission crite	eria are standards by						
	which a client ca	an be deemed appropriate						
	for admission.	These standards include						
	The Agency is	s capable of providing the						
	needed care or s	ervice at the level of						
	intensity the clie	ent's condition requires						
	The services and	l care must conform with						
	current profession	onal standards of practice						
	for the respectiv	e discipline and should						
	be reasonable an	nd necessary to the						
	treatment of a m	edical disorder						
	Agency will not	admit client or continue						
	to provide service	ees in the following						
	situations Sco	pe and complexity of						
	needs cannot be	met by agency, Skills						
	and suitability of	f agency personnel are						
	not adequate to	meet client needs The						
	admission profes	ssional will verify all the						
	information on t	he Intake Form with the						
	client / caregiver	r Review the plan for						
	services, treatme	ent, and care with the						
	client / caregiver	r and obtain input when						
	possible Upor	acceptance and						
		lient, the admitting						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 16 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		157653	B. W	ING		09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
D. 1011 I.					TATE RD 67		
RN2U IN	C			MOORE	ESVILLE, IN 46158		
(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 APPROPRIATION DEFICIENCY)		ON
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGHACI	DATE	
	_	e / Therapist will assign the appropriately skilled					
		f the agency cannot fulfill					
	-	the agency cannot furmi lth care need, a referral					
	_	the other appropriate					
		urces and referral source					
	will be notified.						
	will be notified.	••••					
	C. Based on obs	servation, clinical record					
		w and interview, the					
		ailed to ensure the clinical					
		e coordinated effectively					
		an and contracted therapy					
		e furnishing services for 1					
		lewed of patients					
	receiving therapy	•					
	Findings include	e:					
	10 01:::::1	1					
		ord number 16, SOC					
	` ''	or certification period					
		7/15 and 05/18/15 to					
	07/16/15 with or	rders for skilled nursing,					
	physical and occ	cupational therapy					
	services.						
		rge summary from a					
	_	acility dated 03/17/15,					
	_	tient had a past medical					
		tion pneumonia and					
	J 1 C	physician's assessment					
	_	eumonia was resolved					
	but remains high	aspiration risk					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 17 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
TAG	secondary to dys discharge was mectar thickened caregiver to refer more information liquids. The sumpatient was to be speech therapy.  b. A signed 03/17/15, indicated discharged home services.  c. Review on notes indicated the services indicated the services and drinking. Pt spell this mornin SN had pt break take with ensure patient tuck in chemical services.	phagia. Diet at echanical soft diet with liquids, and for patient / r to speech therapist with n on nectar thickened mary indicated the discharged home with  prescription dated ted the patient was to be with speech therapy  If the skilled nursing	TAG	DEFICIENCY)	
		I patient needs were a speech therapist.			
		7/15: " Instructed pt on aspiration and encourage			

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 18 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			ILDING	nstruction 00	(X3) DATE COMPL <b>09/14</b> /	ETED			
NAME OF F	PROVIDER OR SUPPLIEF	2	•	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	•	chin when swallowing							
		ning with liquids "							
		iled to evidence that the							
		een notified and patient							
	therapist.	dinated with a speech							
	merapist.								
	3 04/20	0/15: " SN instructed pt							
		echniques, thickening of							
	fluids" The visit note failed to								
	evidence that the physician had been								
	notified and pati	* *							
	coordinated with	a speech therapist.							
	4. 05/04	4/15: " Instructed pt on							
	thin tuck when d	Irinking and eating SN							
	instructed pt on	hydration nutrition and							
	thickening of flu	ids " The visit note							
	failed to evidence	e that the physician had							
		d patient needs were							
	coordinated with	a speech therapist.							
	5 05/0	7/15: " SN instructed pt							
		ove swallowing tuck in							
	,	g meds [medications]							
	`	The visit note failed to							
		e physician had been							
	notified and pati								
	_	a speech therapist.							
		- *							

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 19 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00			(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157653		A. BUILDING 00  B. WING			COMPLETED 09/14/2015	
		107000	2. ,,,	_	ADDRESS CITY STATE 7IB CODE	03/14/	2010	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
RN2U IN			_	MOORE	ESVILLE, IN 46158			
(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 APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
		,						
	6. 05/15	5/15: Recertification						
	reassessment ind	licated the patient had a						
	functional limita	tion of swallowing,						
	safety measures	precautions of						
	aspiration and th	at. Physical and						
	occupational the	rapy was on hold for						
	re-evaluation aft	er the speech therapist						
	was to help with	swallowing, increase						
	nutrition, and inc	crease strength. The						
	patient was recer	tified to home health						
	care with skilled	nursing, aide and speech						
	therapy. The ski	lled nurse instructed and						
	reviewed with pa	atient ways to help						
	decrease aspirati	on. The skilled nurse						
	educated patient	/ family on dosage of						
	thick it [powder	substance to be added to						
	fluids to increase	e thickness] to be placed						
	in liquids. Recer	tification Summary						
	indicated the pat	ient's appetite has been						
	decreased and sp	eech therapy was to see						
	the patient for sv	vallowing concerns. The						
	skilled nurse ind	icated she had						
	coordinated with	physician, physical,						
	occupational, and	d speech therapy but did						
	not specify who	the clinicians were. The						
	clinical record fa	illed to evidence patient						
	needs were coord	dinated with a speech						
	therapist.	-						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 20 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157653	<u> </u>			COMPLETED 09/14/2015
		137033	2. ,,	_	ADDRESS, CITY, STATE, ZIP CODE	09/14/2013
NAME OF F	PROVIDER OR SUPPLIER				TATE RD 67	
RN2U IN					ESVILLE, IN 46158	
(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	``	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		,				
	7. 06/30	0/15: " SN had pt eat				
	banana, glass of	OJ [orange juice] and ate				
	approx ½ bowl o	of cream of wheat then				
	started to have co	oughing spell, unable to				
	finish all of creat	m of wheat " The visit				
	note failed to evi	idence that the physician				
	had been notified	d and patient needs were				
	coordinated with	a speech therapist.				
	8. Skille	ed nursing discharge				
	summary indicat	ed " Summary of Care				
	Provided to Date	by Discharging				
	Discipline: SN f	for eval [evaluation] and				
	assess [assessme	ent CV [cardiovascular] /				
	Resp [respiratory	y] / GI [gastrointestinal] /				
	GU [genitourina	ry] status eval				
	[evaluation] and	assess [assessment]				
	appetite wgt [we					
	thrive) Patient	Condition at Discharge:				
	Problems swallo	wing, keeping food,				
	liquids down, ev	en though using				
	thickener. Wgt l	oss past 2 weeks, 6				
	pounds Discha					
	-	nt [continue] to use				
	thickening. Eat					
		snack thought day.				
		4 Ensure daily with				
		The visit note failed to				

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 21 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		157653	B. W	ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN					STATE RD 67 ESVILLE, IN 46158		
(X4) ID	•	TATEMENT OF DEFICIENCIES	1	ID	-0 VILLE, IIV 40 100		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e physician had been					
	notified and pati						
	coordinated with a speech therapist.						
		1.1					
	_	onal therapy notes					
	indicated the foll	lowing:					
	1. 04/08	8/15: " Pt doing fair					
		omplained of difficulty					
	swallowing. OTR [Occupational						
	Therapist Registered] educated pt						
	[patient] / [spous	se] / daughter on need for					
	pt [patient] to us	e thickened liquids. Dtr					
	[daughter] states	he won 't drink					
	anything with th	ickener 2* [* secondary]					
	taste. OTR reco	mmended premixed					
	thickened liquids	s Teaching / Training:					
	Swallowing tech	nique - chin tuck &					
	[and] thickener r	needs " The visit note					
	failed to evidence	e that the physician and					
	case manager ha	d been notified and					
	patient needs we	ere coordinated with a					
	speech therapist.						
		5/15: " Pt reported pain					
		ble with swallowing.					
	_	t on drinking thickened					
	_	ng bites of crushed up					
	meds in applesau	uce or pudding and					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 22 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00  B. WING			ETED
		157653	B. W	_		09/14/	2015
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				TATE RD 67 ESVILLE, IN 46158		
		TA TIPL (FIVE OF DEPLOYED CITY	1		-0 VILLE, IIV +0 100		975
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY 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)	ΓE	DATE
	taking small am	ounts of meds. Pt					
	reported taking a	a pill one day and					
	coughing it back	up the next day "The					
	visit note failed to evidence that the						
	physician and case manager had been						
	notified and pati	ent needs were					
	coordinated with a speech therapist.						
	3. 04/22/15 note indicated pt was						
	having difficulty swallowing. The visit						
	note failed to evidence that the physician						
	and case manage	er had been notified and					
	_	ere coordinated with a					
	speech therapist.						
	4. 05/12	2/15 note indicated the					
	patient was havi	ng difficulty swallowing					
	1 *	akness. The patient's					
	· ·	6 on a scale from one to					
	_	g the worse. The patient					
	1	ined of neck and throat					
	_	lowing difficulties and					
	1	" The visit note					
		te that the physician and					
		id been notified and					
	_	ere coordinated with a					
	speech therapist.						
	5. 05/19	9/15: " Pain level 4/5					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 23 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157653	B. W	'ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				ESVILLE, IN 46158		
(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)	ATE	COMPLETION DATE
	at the neck and t	hroat, decrease					
	endurance "	The visit note failed to					
	evidence that the	e physician and case					
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
	6. 05/2	1/15: " Pt continues to					
	complain about l	his throat Discussed					
	importance of nu	itrition and drinking					
	ensure if pt is un	able to swallow and					
	cannot eat regula	ar diet on any particular					
	day" The vis	it note failed to evidence					
	that the physicia	n and case manager had					
	been notified and	d patient needs were					
	coordinated with	a speech therapist.					
	7. 05/2:	5/15: " Pt required max					
		llowing food to tuck his					
		as running through entire					
		coughing and spitting /					
	1 .	d. Pt was very upset and					
		food. Discussed pt					
	drinking ensure	later due to lack of					
	nutrients Pain	to the neck at a level 5					
	" The visit no	te failed to evidence that					
	the physician and	d case manager had been					
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 24 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. W	ING		09/14/	2015
NAME OF I	ROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				ESVILLE, IN 46158		
(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 APPROPRIATE DEFICIENCY)		DATE
	pt he / she report all day due to be mod [moderate] [sic] for tucking swallowing Pt this day " The evidence that the manager had been needs were coord therapist.  9. 6/11/ waking up early he was unable to stated [illegible]	6/15: " When talking to ted he / she hadn't eaten sing weak Pt required / max [maximum] v/c his /her chin when table to keep food down to evisit note failed to exphysician and case en notified and patient dinated with a speech with the reported and having breakfast but to keep it down Pt writing] for told him / expected ensures a day v/c					
	required extra tin	tuck chin to swallow. Pt me to eat due to problems  " The visit note					
	٠	te that the physician and					
	· ·	d been notified and					
	patient needs we speech therapist.	ere coordinated with a					
	10. 06/2	14/15: " Pt took v/c [sic] required to tuck ing " The visit note					

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			ILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF F	ROVIDER OR SUPPLIER			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY S' (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)	TE	(X5) COMPLETION DATE
	failed to evidence	e that the physician and					
	· ·	d been notified and					
	patient needs we	re coordinated with a					
	speech therapist.						
	11. 06/19/15: " Swallowing						
	difficulty Speech slow, garbled (wet),						
	Pt is continuing to have weight loss and						
	difficulty swallowing. Pt has met max						
	potential d/t [due to] these barrier. Pt is						
	slow to progress and states he gets worn						
		tle he currently does. Pt					
		eficits affecting progress					
		e visit note failed to					
		e physician and case					
	_	en notified and patient					
		dinated with a speech					
	therapist.						
	. Di	d					
		therapy notes indicated					
	the following:						
	1 05/05	5/15: " Pt [patient]					
		coughing and choking on					
	•	The visit note failed to					
		e physician and case					
		en notified and patient					
	_	dinated with a speech					
	therapist.	·· -r · · · · ·					
	•						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 26 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157653	A. BUILDING 00  B. WING	(X3) DATE SURVEY COMPLETED 09/14/2015
NAME OF PROVIDER OR SUPPLIER RN2U INC	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
2. 05/07/15: " Pt reports have lost weight and not eating well" The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.  3. 05/11/15: " Pt having difficulty progressing due to decrease nutrition intake" The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.  4. 05/14/15: " Pt reports confusion over preparation of food with thickener. Pt was finishing bowl of cream of wheat when PT [physical therapy] present. He / she appeared to aspirate it and vomited it all back up. Pt having increased difficulty with nutrition" The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.  5. 05/25/15: " Pt seated in		

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPL <b>09/14</b> /	ETED
NAME OF I	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
		shed with breakfast. Pt is itting in trash can "					
	1 .	iled to evidence that the					
	1 ~ ~	se manager had been					
	notified and pati						
	coordinated with	a speech therapist.					
	6. 06/1	6/15: " Pt reports cont					
	difficulty with swallowing and choking.						
	Pt appears to have						
	appears malnourished Pt's strength						
		ly possibly due to lack of					
	_	ech: See ST [speech					
	1 1 1	owing: See ST " The					
		to evidence that the					
		se manager had been					
	notified and pati	a speech therapist.					
	coordinated with	i a speech therapist.					
	7. 06/13	8/15: " Pt drank					
	thickened orange	e juice and had difficulty					
	with aspiration /	coughing " The visit					
	note failed to ev	idence that the physician					
	and case manage	er had been notified and					
	patient needs we	ere coordinated with a					
	speech therapist						
	8. 06/22	2/15: " Reports not					
		not eating due to					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 28 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653		UILDING	onstruction  00	(X3) DATE COMPL 09/14	ETED	
NAME OF F	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	choking" The	e visit note failed to						
	evidence that the	e physician and case						
	manager had bee	en notified and patient						
	needs were coor	dinated with a speech						
	therapist.							
	9. 06/2: feeling well with produce words a reports has not e color not good, whaving diff [diffidue to decreased weak at this time failed to evidence case manager has	5/15: " Pt reports not a diff [difficulty] to as pt is so weak. Pt aten in days Pt's skin very frail and weak. Pt ituelty] making progress I nourishment. Pt is very e " The visit note be that the physician and ad been notified and ere coordinated with a						
	speech therapist.							
	10. 06/2 with nurse eating Pt still coughing pt doing well IV fluids for sho visit. Pt still inc fatigue " The evidence that the manager had bee	30/15: " Pt in kitchen g with encouragement. with eating / swallowing and presents better after ort ER [emergency room] rease weakness and e visit note failed to e physician and case en notified and patient dinated with a speech						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 29 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED 09/14/2015	
		157653	B. W.			09/14/	2015
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
DNOLLIN	0				STATE RD 67		
RN2U IN				MOORE	ESVILLE, IN 46158		
(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 APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		LSC IDENTIFFING INFORMATION)		TAG			DATE
	therapist.						
	<b>2</b> G F51						
		istrator was interviewed					
	on 09/14/15 at 1						
	Administrator st	• .					
		patient and proceeded to					
	review the patier						
		ated she had performed					
	the patient's adm						
	Administrator was not able to answer nor						
	explain why speech therapy was not						
		patient's case when it was					
		hysician at discharge.					
		or stated the case					
	_	ed in the patient's case					
	retired from the	agency. During this					
	•	istrator emailed and					
		cted therapy company					
	and left message	s for the coordinator to					
	return her phone	call.					
	3C. On 09/14/1:	5 at 1:53 PM, the					
	Administrator ha	nd a return call from the					
	contracted therap	by company. The					
	Administrator ha	nd stated that the					
	coordinator from	the contracted therapy					
	company indicat	ed that a speech therapist					
	had made contac	et with the spouse in July					
	but the services	was declined due to the					
	patient was "too	far gone." The					
	Administrator sta	ated the speech therapist					
	did not go out to	see the patient to make					
	that assessment /	judgment and the					
	Administrator sta	ated she did not know					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 30 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		00	COMPLET 09/14/20	ED	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE (	(X5) COMPLETION DATE	
	who the speech therapist was. A communication note dated 03/26/15, was provided by Employee N, a home health aide / office worker, during this time. Employee N wrote "According to [Name of therapy company] ST [speech therapy], ST had called numberous [sic] times with no return call to ST. Dr. [doctor] notified." Employee N was interviewed at this time and stated she did not remember who the speech therapist was and she did not know who the speech therapist spoke with at the physician office and did not know what day and time the speech therapist notified the physician.  4C. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and informed the office of the patient's difficulty with swallowing. The complainant stated that they (patient and family caregivers) were not aware that the patient was not getting speech therapy for some of the staff portrayed themselves as speech therapists. The complainant stated no one had called and left messages nor was any speech therapy services had been declined. The					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 31 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	ì ,	ILDING	NSTRUCTION  00	(X3) DATE COMPL 09/14/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	discovered this v came to the hom physical therapy the patient had g	icated how he / she was by a therapist that e and was discussing  The complainant stated otten so weak that he / a skilled nursing facility therapy.						
	2:55 PM, the Ad the speech therapy the said therapy communication Employee N had the speech therap	ning inside the agency at ministrator stated that pist was not provided by company on the note dated 03/26/15 that provided / indicated, but pist was provided therapy company.						
	indicated, "All p services shall ma that their efforts effectively and s outlined in the P done through for maintaining com Plans; and writte The Primary N responsibility fo Care Plan and co caregivers within	ersonnel furnishing aintain a liaison to assure are coordinated upport the objectives lan of Care. This may be rmal care conferences; uplete, current Care en and verbal interaction Nurse will assume r updating / changing the enmunicating changes to in twenty - four [24] hours						
		nference or changes.						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 32 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  157653		onstruction  00	(X3) DATE SURVEY COMPLETED 09/14/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	The physician will be contacted when his / her approval for that change is necessary and to alert physician to changes in client condition.  5C. An undated policy titled "RN Case Manager" indicated, " Collaborates with physicians, other health care professionals [therapists supportive services], clients, and families in developing a comprehensive, coordinated plan of care "  6C. An undated policy titled Coordination of Client Services indicated, "After initial assessment, the admitting Registered Nurse / Therapist shall discuss the findings of the initial visit with the Clinical manager to ensure "					
G 0143 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on observation, record review and interview, the agency failed to ensure their efforts were coordinated effectively with the physician and contracted therapy agency that were furnishing services for 1 of 4 records reviewed of patients	G 0143	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint			

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 33 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157653			09/14/	2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
1(1/20   1/0			WOOK				
(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
	receiving therap	y services. (#16)			document conversation		
					andsign/date form. (On-going)		
	Findings include	e:			3. Patient records requested to be		
					mailed will be mailedcertified mail		
	1 Clinical reco	rd number 16, SOC (start			return receipt requested. (On-going	)	
		ification period 03/19/15			4. DON/designee will notify		
	, ,	•			patient/family same day it isdetermined agency cannot provide		
		05/18/15 to 07/16/15			a discipline. (On-going)	e	
		killed nursing, physical			5. DON/designee will notify MD		
	and occupationa	l therapy services.			same day it is determinedagency		
					cannot provide a discipline.		
	<ul> <li>a. A dischar</li> </ul>	rge summary from a			(On-going)		
	skilled nursing f	facility dated 03/17/15,			6. DON/designee will review all		
		tient had a past medical			admissions to ensure agencycan		
	_	tion pneumonia and			provide ordered disciplines and that	t	
		physician's assessment			all ordered disciplines are scheduled	d.	
	1				(On-going)		
	_	eumonia was resolved			7. When agency uses a staffing		
	but remains high	-			agency to cover a		
	secondary to dys	sphagia. Diet at			disciplineDON/designee will tract al	I	
	discharge was m	echanical soft diet with			communications with the staffing		
	nectar thickened	liquids, and for patient /			agency to ensurethere is timely		
	caregiver to refe	r to speech therapist with			follow up. (On-going)		
	1	n on nectar thickened			8. When a staffing agency is used,		
		nmary indicated the			DON/designee will contactstaffing		
	_	•			agency daily, Mon-Fri, for		
	-	e discharged home with			coordination of care. All contact will	l	
	speech therapy.				bedocumented in the appropriate		
					patient's chart. (On-going)  9. If patient/caregiver declines		
	b. A signed	prescription dated			therapy services,DON/designee will		
	03/17/15, indica	ted the patient was to be			contact patient/family no later than		
	discharged home	e with speech therapy			next business day toconfirm they		
	services.				declined therapy. Conversation will		
					be documented in		
	c Review o	of the skilled nursing			appropriatepatient's chart.		
		•			(On-going)		
	notes indicated t	ne iollowing:			10. DON/designee will in-service		
					professional on requirements		

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
		157653	B. W	ING		09/14/	2015
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
KINZU IIV	<u> </u>			WOOKE	=3 VILLE, IN 40 130		
(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	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. 04/0	8/15: " SN [skilled			contact all disciplines involved in		
	nursing] instruct	ed and reviewed with pt			patient's care and document name		
		chin down when eating			ofperson spoke with along with date	9	
		t stated had coughing			and time. (On-going)		
		0 0			11. DON/designee will in-service		
	_	ng while eating breakfast.			staff on requirement tonotify MD of	:	
		multivitamin in half and			changes in patient's condition and		
	take with ensure	while SN watched			document in patient's chart.		
	patient tuck in cl	hin " The visit note			(On-going)		
	failed to evidence	e that the physician had			12. DON/designee will ensure all		
		d patient needs were			disciplines involved inpatient's care		
		a speech therapist.			will participate in case conference.		
	coordinated with	i a specen merapist.			(On-going)		
	2 04/1	7/15: " Instructed pt on					
		•					
		aspiration and encourage					
		chin when swallowing					
		ning with liquids "					
	The visit note fa	iled to evidence that the					
	physician had be	een notified and patient					
		dinated with a speech					
	therapist.	one of the second					
	therapist.						
	2 04/2	0/15. " CNI :					
		0/15: " SN instructed pt					
		echniques, thickening of					
	fluids " The	visit note failed to					
	evidence that the	e physician had been					
	notified and pati	ent needs were					
	1	a speech therapist.					
		,					
	4. 05/04	4/15: " Instructed pt on					
		lrinking and eating SN					
		hydration nutrition and					
		•					
	_	ids " The visit note					
		ee that the physician had					
	been notified and	d patient needs were					

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	coordinated with	a speech therapist.					
	5. 05/0' on ways to impreshin when taking fluids food" evidence that the notified and paticoordinated with 6. 05/1: reassessment incomparison and the occupational limital safety measures aspiration and the occupational the re-evaluation after was to help with nutrition, and impatient was received with skilled therapy. The skilled therapy. The skilled therapy with producted patient thick it [powder fluids to increase in liquids. Received and specific the patient for systilled nurse indicoordinated with coordinated with the patient for systilled nurse indicoordinated with coordinated with the patient for systilled nurse indicoordinated with coordinated with coordinated with the patient for systilled nurse indicoordinated with coordinated with coordinated with the patient for systilled nurse indicoordinated with coordinated with coordinated with the patient for systilled nurse indicoordinated with coordinated with coordinated with coordinated with the patient for systillary in the patient for systillary in the patient for systillary indicated the patient for systillary indicated the patient for systillary indicated with patient for systillary indicated the patient for systil	7/15: " SN instructed pt ove swallowing tuck in g meds [medications] The visit note failed to e physician had been ent needs were a speech therapist.  5/15: Recertification licated the patient had a tion of swallowing, / precautions of eat. Physical and rapy was on hold for er the speech therapist swallowing, increase crease strength. The rtified to home health nursing, aide and speech illed nurse instructed and eatient ways to help on. The skilled nurse / family on dosage of substance to be added to et thickness] to be placed tification Summary ient's appetite has been beech therapy was to see wallowing concerns. The icated she had a physician, physical,					
	occupational, all	d speech therapy but did					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 36 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING (1) COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00		
157653			B. W	ING		09/14/2	015
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
DNOLLIN	0				STATE RD 67		
RN2U INC				MOORE	ESVILLE, IN 46158		
(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 APPROPRIATE DEFICIENCY)	ΤE	COMPLETION DATE
TAG		,		TAG			DATE
		the clinicians were. The illed to evidence patient					
		dinated with a speech					
	therapist.	dinated with a speech					
	merapist.						
	7 06/20	V/15: " SNI had nt out					
		0/15: " SN had pt eat OJ [orange juice] and ate					
		nately] ½ bowl of cream					
	** - **	rited to have coughing					
		inish all of cream of					
		visit note failed to					
		e physician had been					
		1 2					
	notified and patie						
	coordinated with	a speech therapist.					
	0 C1;i11	ed nursing discharge					
		ed " Summary of Care					
	Provided to Date	•					
		for eval [evaluation] and					
	•	nt CV [cardiovascular] /					
	-	y] / GI [gastrointestinal] /					
	GU [genitourina						
		assess [assessment]					
	appetite wgt [we						
		Condition at Discharge:					
	,	wing, keeping food,					
	liquids down, ev						
	_	oss past 2 weeks, 6					
	pounds Discha	•					
	*	nt [continue] to use					
	thickening. Eat						
	_	sm [sman] freq snack thought day.					
		4 Ensure daily with					
		•					
	unckener "	The visit note failed to					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 37 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		l í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	notified and pati	e physician had been ent needs were a a speech therapist.						
	d. Occupati indicated the fol	onal therapy notes lowing:						
	today. Pt c/o [co swallowing. OT Therapist Regist [patient] / [spous pt [patient] to us [daughter] states with thickener 2 OTR recommend liquids Teaching Swallowing tech [and] thickener in failed to evidence case manager ha	nique - chin tuck & needs " The visit note e that the physician and d been notified and re coordinated with a						
	in neck and troul Educated patient liquids after taking meds in applesant taking small amoreported taking a coughing it back visit note failed	5/15: " Pt reported pain ble with swallowing. c on drinking thickened ing bites of crushed up ace or pudding and bunts of meds. Pt in pill one day and in up the next day "The to evidence that the se manager had been						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 38 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
AND TEAN	or condition	157653	B. WI		00	09/14/	
		107000		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	00/11/	2010
NAME OF I	PROVIDER OR SUPPLIEF	₹			TATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(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 DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	notified and pati						
	coordinated with	a speech therapist.					
	2 04/2	2/15 note indicated pt was					
		swallowing. The visit					
		idence that the physician					
		er had been notified and					
	_	ere coordinated with a					
	speech therapist						
	specen merupist	•					
	4 05/13	2/15 note indicated the					
		ng difficulty swallowing					
	-	akness. The patient's					
	_	6 on a scale from one to					
	_	g the worst. The patient					
	_	ined of neck and throat					
	•	lowing difficulties and					
		" The visit note					
	failed to evidence	ce that the physician and					
		id been notified and					
	patient needs we	ere coordinated with a					
	speech therapist.						
	5. 05/19	9/15: " Pain level 4/5					
	at the neck and t	hroat, decrease					
	endurance "	The visit note failed to					
	evidence that the	e physician and case					
	_	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
		1/15 11 70					
		1/15: " Pt continues to					
	•	his throat Discussed					
	importance of nu	utrition and drinking					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 39 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			JILDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/14</b>	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE	
TAG	ensure if pt is un cannot eat regula day" The vis that the physicia been notified and coordinated with 7. 05/25 u/c [sic] for swalchin. Pt nose was meal and pt kept throwing up food wouldn't finish drinking ensure nutrients Pain" The visit not the physician and notified and pati coordinated with 8. 05/26 pt he / she report all day due to be mod [moderate] [sic] for tucking swallowing Pt	able to swallow and ar diet on any particular it note failed to evidence in and case manager had dipatient needs were a speech therapist.  5/15: " Pt required max lowing food to tuck his as running through entire coughing and spitting / d. Pt was very upset and food. Discussed pt later due to lack of to the neck at a level 5 te failed to evidence that dicase manager had been		TAG	DEFICIENCY)		DATE	
	manager had bee	e physician and case on notified and patient dinated with a speech						
		15: " He reported and having breakfast but						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 40 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		00	COMPI 09/14			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	he was unable to keep it down Pt stated [illegible writing] for told him / her to drink three ensures a day v/c [sic] required to tuck chin to swallow. Pt required extra time to eat due to problems with swallowing " The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.  10. 06/14/15: " Pt took medication and v/c [sic] required to tuck chin on swallowing " The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.  11. 06/19/15: " Swallowing difficulty Speech slow, garbled (wet), Pt is continuing to have weight loss and difficulty swallowing. Pt has met max potential d/t [due to] these barrier. Pt is slow to progress and states he gets worn out with what little he currently does. Pt has nutritional deficits affecting progress as well " The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.  e. Physical therapy notes indicated						

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 41 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL			
		157653	B. W		<u> </u>	09/14/		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	<b>{</b>	635 S STATE RD 67					
RN2U IN	С			MOORE	ESVILLE, IN 46158			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
TAG	the following:	LESC IDENTIFTING INFORMATION)		TAG			DATE	
	the following.							
	1. 05/0:	5/15: " Pt [patient]						
		coughing and choking on						
	food / meds "	The visit note failed to						
	evidence that the	e physician and case						
	manager had bee	en notified and patient						
	needs were coor	dinated with a speech						
	therapist.							
	2 05/0	7/15 11 70 11						
		7/15: " Pt reports have						
	•	not eating well " The						
		to evidence that the						
	notified and pati	se manager had been						
	•	a speech therapist.						
	coordinated with	i a specen therapist.						
	3. 05/1	1/15: " Pt having						
		ssing due to decrease						
	nutrition intake	" The visit note failed						
	to evidence that	the physician and case						
	manager had bee	en notified and patient						
		dinated with a speech						
	therapist.							
	4 OF/1	1/15. " Dt rangeta						
		4/15: " Pt reports preparation of food with						
		as finishing bowl of						
		when PT [physical						
		sent. He / she appeared to						
	***	omited it all back up. Pt						
	_	difficulty with nutrition						
	" The visit note failed to evidence that							
	the physician an	d case manager had been						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	notified and pati coordinated with	ent needs were a speech therapist.						
	kitchen and finis coughing and sp The visit note fa physician and ca notified and pati	5/15: " Pt seated in hed with breakfast. Pt is itting in trash can " illed to evidence that the se manager had been ent needs were a speech therapist.						
	6. 06/16/15: " Pt reports cont [continued] difficulty with swallowing and choking. Pt appears to have lost weight and appears malnourished Pt's strength decreased slightly possibly due to lack of nutrition Speech: See ST [speech therapy]; Swallowing: See ST " The visit note failed to evidence that the physician and case manager had been notified and patient needs were coordinated with a speech therapist.							
	thickened orange with aspiration / note failed to evand case manage patient needs we speech therapist.  8. 06/22	8/15: " Pt drank e juice and had difficulty coughing " The visit idence that the physician er had been notified and re coordinated with a  2/15: " Reports not not eating due to						
	feeling well and	-						

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO UILDING	NSTRUCTION 00	COMPL			
		157653	B. W	ING	<u> </u>	09/14/		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
			635 S STATE RD 67					
RN2U IN					ESVILLE, IN 46158			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY 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)	ATE	DATE	
	evidence that the	e physician and case						
	-	en notified and patient						
		dinated with a speech						
	therapist.							
	9 06/2:	5/15: " Pt reports not						
		n diff [difficulty] to						
	produce words a	s pt is so weak. Pt						
	*	aten in days Pt's skin						
		very frail and weak. Pt						
		iculty] making progress						
		I nourishment. Pt is very e " The visit note						
		that the physician and						
		d been notified and						
	_	ere coordinated with a						
	speech therapist.							
	10 06/	30/15: " Pt in kitchen						
		g with encouragement.						
		with eating / swallowing						
		and presents better after						
		ort ER [emergency room]						
		rease weakness and						
		e visit note failed to e physician and case						
		en notified and patient						
	_	dinated with a speech						
	therapist.	•						
	f. Social wo	ork visit notes indicated						
	the following:							
	1. 06/03	3/15: Reason for visit:						

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 44 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		r í	UILDING	onstruction  00	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE	
	"Possible placen	nent: Assisted Living,						
	g/tube [gastrosto	omy tube] His / her						
	biggest concern	is having to eat nectar						
	consistency food	ls / drinks 2* [*						
	secondary] swall	lowing difficulties. He /						
	she really doesn'	t want g/tube placement						
	Risk factors -	pt [patient] has trouble						
	swallowing and	then laying down "						
	The visit note far	iled to evidence that the						
	physician had be	een notified.						
	2. 06/24	4/15: Reason for visit:						
	"Assisting with a	g/tube placement						
	concerns Pt is	visibly smaller since last						
	visit on 6/3. Sta	tes his energy level is						
	poor and not eat	ing well at all " The						
	visit note failed	to evidence that the						
	physician had be	een notified.						
	2. The Adminis	trator was interviewed on						
	09/14/15 at 11:4	5 AM. The						
		ated she vaguely						
		patient and proceeded to						
	review the patien	ated she had performed						
	the patient's adm	_						
	•	as not able to answer nor						
	explain why spe	ech therapy was not						
	_	patient's case when it was						
		hysician at discharge.						
		or stated the case						
	_	ed in the patient's case						
	reured from the	agency. During this						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 45 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		lì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/14	LETED	
NAME OF I	PROVIDER OR SUPPLIER			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	called the contra	istrator emailed and cted therapy company s for the coordinator to call.					
	contracted theray Administrator had coordinator from company indicate had made contact but the services patient was "too Administrator st did not go out to that assessment Administrator st who the speech to communication provided by Empaide / office wor Employee N wro of therapy compatherapy], ST had times with no reasonable interviewed at the did not remember therapist was and the speech therapphysician office	and a return call from the by company. The and stated that the in the contracted therapy ed that a speech therapist of with the spouse in July was declined due to the far gone." The ated the speech therapist see the patient to make yight judgment and the ated she did not know therapist was. A mote dated 03/26/15, was ployee N, a home health ker, during this time.					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 46 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ì í	JILDING	onstruction  00	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	o9/14/15 at 2:40 stated that the paragivers were the patient would therapy. The costaff would notifi informed the off difficulty with secomplainant state family caregiver the patient was refor some of the secomplainant state left messages no services had been complainant independent of the secomplainant independent independen	told upon admission that d be getting speech implainant stated that the fly the office often and fice of the patient's wallowing. The led that they (patient and les) were not aware that floot getting speech therapy staff portrayed leech therapists. The led no one had called and r was any speech therapy in declined. The licated how he / she was by a therapist that lee and was discussing and the complainant stated lotten so weak that he / a skilled nursing facility in therapy.  In ginside the agency at liministrator stated that post was not provided by						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 47 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		r í	JILDING	onstruction  00	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	indicated, "All p services shall may that their efforts effectively and so outlined in the P done through for maintaining com Plans; and writte The Primary Presponsibility for Care Plan and concaregivers withing following the contract the physician work of her approval for necessary and to changes in clients. An undated preservices of the physicians, professionals [the services], clients developing a complan of care"  8. An undated prof Client Service assessment, the answer of Therapis	ersonnel furnishing aintain a liaison to assure are coordinated upport the objectives lan of Care. This may be mal care conferences; aplete, current Care en and verbal interaction Nurse will assume r updating / changing the ommunicating changes to a twenty - four [24] hours inference or changes. ill be contacted when his r that change is alert physician to a condition.  olicy titled "RN Case ted," Collaborates other health care erapists supportive a and families in imprehensive, coordinated						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 48 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		lì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/14/	ETED		
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	personnel furnishmaintain a liaiso efforts are coord support the object Plan of Care. The formal care confiction complete, current and verbal interaction within twenty - for the conference of will be contacted for that change is physician to character for the conference of the consult and collar registered nurse. The therapist with implementing the and evaluating communicates physician and to and other Agence plan, written prospective.	who is the case manager.  Il participate in e physician's plan of care lient progress "  policy titled herapy indicated, " blans and changes to the nursing Case Manager y Staff through the care						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 49 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING <u>00</u> COM			ETED
		157653	B. WING			09/14/	2015
			ST	TREET ADI	DRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ATE RD 67		
RN2U IN	C				SVILLE, IN 46158		
					7 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13		
(X4) ID		STATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	17	AG	DETCIENCT)		DATE
G 0144	484.14(g)						
	,	OF PATIENT SERVICES					
Bldg. 00		d or minutes of case					
		blish that effective					
	interchange, repo patient care does	rting, and coordination of occur.					
		vation, record review and	G 0144	ı			10/16/2015
		gency failed to ensure			1. Administrator/designee will		
	,	e coordinated and		С	complete a patient complaintform		
		ectively with the		v	when receiving a complaint.		
		ontracted therapy agency		,	On-going)		
		hing services for 1 of 4			2. All complaint forms will be given		
		•			o Administrator sameday to review		
		d of patients receiving			contact person(s) making complaint,	,	
	services. (#16)				document conversation andsign/date form. (On-going)		
					3. Patient records requested to be		
	Findings include	<del>2</del> :			mailed will be mailedcertified mail		
					eturn receipt requested. (On-going)	)	
	<ol> <li>Clinical reco</li> </ol>	rd number 16, SOC (start		4	1. DON/designee will notify		
	of care), for cert	tification period 03/19/15		р	patient/family same day it		
	to 05/17/15 and	05/18/15 to 07/16/15		is	sdetermined agency cannot provide	9	
	with orders for s	skilled nursing, physical			a discipline. (On-going)		
		al therapy services.			5. DON/designee will notify MD		
					same day it is determinedagency		
	a A discha	rge summary from a			cannot provide a discipline.		
		facility dated 03/17/15,			On-going) 5. DON/designee will review all		
		•			admissions to ensure agencycan		
	_	tient had a past medical			provide ordered disciplines and that	:	
		tion pneumonia and		I .	all ordered disciplines are scheduled		
		physician's assessment			On-going)		
	indicated the pn	eumonia was resolved		7	7. When agency uses a staffing		
	but remains high	n aspiration risk			agency to cover a		
	secondary to dy	sphagia. Diet at		d	disciplineDON/designee will tract all		
		nechanical soft diet with		С	communications with the staffing		
		l liquids, and for patient /			agency to ensurethere is timely		
	inicitoffet	quiao, and for patient,		f	follow up. (On-going)		

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 50 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
		157653	B. W	ING		09/14/	2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t		635 S S	STATE RD 67		
RN2U IN	С		MOORESVILLE, IN 46158				
(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	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	caregiver to refe	r to speech therapist with			8. When a staffing agency is used,		
	more informatio	n on nectar thickened			DON/designee will contactstaffing		
	liquids. The sun	nmary indicated the			agency daily, Mon-Fri, for		
	patient was to be	e discharged home with			coordination of care. All contact will		
	speech therapy.	C			bedocumented in the appropriate		
	special interpr				patient's chart. (On-going)  9. If patient/caregiver declines		
	h A signad	prescription dated			therapy services,DON/designee will		
		• •			contact patient/family no later than		
	· ·	ted the patient was to be			next business day toconfirm they		
	1	e with speech therapy			declined therapy. Conversation will		
	services.				be documented in		
					appropriatepatient's chart.		
	c. Review o	of the skilled nursing			(On-going)		
	notes indicated t	he following:			10. DON/designee will in-service		
					professional on requirementto		
	1. 04/08	8/15: " SN [skilled			contact all disciplines involved in		
		ed and reviewed with pt			patient's care and document name		
		chin down when eating			ofperson spoke with along with date	9	
		stated had coughing			and time. (On-going)		
		• •			11. DON/designee will in-service staff on requirement tonotify MD of	:	
	_	ng while eating breakfast.			changes in patient's condition and		
	•	multivitamin in half and			document in patient's chart.		
		while SN watched			(On-going)		
	_	hin " The visit note			12. DON/designee will ensure all		
		e that the physician had			disciplines involved inpatient's care		
	been notified and	d patient needs were			will participate in case conference.		
	coordinated with	a speech therapist.			(On-going)		
	2. 04/1	7/15: " Instructed pt on					
		aspiration and encourage					
	1 -	chin when swallowing					
	_	ning with liquids "					
		iled to evidence that the					
		een notified and patient					
		dinated with a speech					
	therapist.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	NSTRUCTION  00	COMPL	ETED			
		157653	B. W	ING		09/14/	/2015		
NAME OF	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158						
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	on swallowing to fluids " The evidence that the notified and pati coordinated with 4. 05/04 thin tuck when do instructed pt on thickening of fluids failed to evidence been notified and coordinated with 5. 05/07 on ways to improchin when taking fluids food " evidence that the notified and pati coordinated with 6. 05/13 reassessment incomparison of the functional limital safety measures aspiration and the occupational the re-evaluation aft was to help with nutrition, and incomparison."	14/15: " Instructed pt on Irinking and eating SN hydration nutrition and tids " The visit note that the physician had did patient needs were in a speech therapist.  17/15: " SN instructed pt to swallowing tuck in the gradient medications.  The visit note failed to be physician had been the end a speech therapist.  15/15: Recertification dicated the patient had a tition of swallowing,							

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157653	B. W		00	09/14/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			TATE RD 67		
RN2U IN	С			MOORE	SVILLE, IN 46158		
(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	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nursing, aide and speech					
	1.5	illed nurse instructed and					
	_	atient ways to help					
		ion. The skilled nurse					
	•	/ family on dosage of					
		substance to be added to					
		e thickness] to be placed tification Summary					
	_	tient's appetite has been					
		beech therapy was to see					
	_	wallowing concerns. The					
	skilled nurse ind						
		n physician, physical,					
		d speech therapy but did					
	-	the clinicians were. The					
		ailed to evidence patient					
		dinated with a speech					
	therapist.	amatea with a specifi					
	unerupisu.						
	7. 06/30	0/15: " SN had pt eat					
	banana, glass of	OJ [orange juice] and ate					
	approx [approxi	mately] ½ bowl of cream					
	of wheat then sta	arted to have coughing					
	spell, unable to t	finish all of cream of					
	wheat " The	visit note failed to					
	evidence that the	e physician had been					
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					
		ed nursing discharge					
	1	ted " Summary of Care					
		e by Discharging					
	-	for eval [evaluation] and					
	assess [assessme	ent CV [cardiovascular] /					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 53 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL			
111121211	or country.	157653	B. W		00	09/14/		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R	635 S STATE RD 67					
RN2U IN	С				ESVILLE, IN 46158			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	<del> </del>	y] / GI [gastrointestinal] /		TAG	DLI ICILI (CT)		DATE	
	GU [genitourina							
	1	assess [assessment]						
	appetite wgt [we							
		t Condition at Discharge:						
	· ·	wing, keeping food,						
	liquids down, ev							
		loss past 2 weeks, 6						
	pounds Disch	*						
	-	ont [continue] to use						
	thickening. Eat	sm [small] freq						
	[frequent] meals	snack thought day.						
	Drink at least 3 -	- 4 Ensure daily with						
	thickener "	The visit note failed to						
	evidence that the	e physician had been						
	notified and pati	ent needs were						
	coordinated with	a speech therapist.						
	d. Occupati	onal therapy notes						
	indicated the fol							
		8/15: " Pt doing fair						
		omplained of] difficulty						
	1	R [Occupational						
		ered] educated pt						
	_	se] / daughter on need for						
		e thickened liquids. Dtr						
	1 2 3	he won't drink anything						
		* [* secondary] taste.						
		ded premixed thickened						
	liquids Teachi	-						
	_	inique - chin tuck &						
		needs " The visit note						
	failed to evidence	e that the physician and						

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 54 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULT A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE : COMPL 09/14/	ETED	
NAME OF F	PROVIDER OR SUPPLIER		6	635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 SVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		d been notified and are coordinated with a					
	in neck and troul Educated patient liquids after taking meds in applesant taking small amore ported taking a coughing it back visit note failed physician and canotified and patic coordinated with 3. 04/22 having difficulty note failed to evand case manage	2/15 note indicated pt was a swallowing. The visit idence that the physician er had been notified and are coordinated with a					
	patient was havi secondary to we pain level was a 10 with 10 being also had compla being sore, swall thick congestion failed to evidence	2/15 note indicated the ng difficulty swallowing akness. The patient's 6 on a scale from one to g the worst. The patient fined of neck and throat lowing difficulties and " The visit note that the physician and d been notified and					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 55 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î í	ULTIPLE CO UILDING	NSTRUCTION  00	(X3) DATE COMPL		
		157653	B. W	ING		09/14/	/2015
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE TATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
ING		re coordinated with a		17.0	<u> </u>		DATE
	5. 05/19 at the neck and the endurance "evidence that the manager had been needs were coordinated with importance of numbers of	hroat, decrease The visit note failed to e physician and case en notified and patient dinated with a speech  1/15: " Pt continues to his throat Discussed attrition and drinking able to swallow and har diet on any particular it note failed to evidence had patient needs were ha a speech therapist.  1/15: " Pt required max had patient needs were had patient needs were had speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had patient needs were had a speech therapist.  1/16: " Pt required max had a speech therapist.  1/16: " Pt required max had a speech therapist.  1/16: " Pt required max had a speech t					
	•						

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			JILDING	nstruction 00	(X3) DATE COMPL 09/14/	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	pt he / she report all day due to be mod [moderate] [sic] for tucking swallowing Pt this day " The evidence that the manager had been needs were coord therapist.  9. 6/11/waking up early he was unable to stated [illegible her to drink three [sic] required to required extra tin with swallowing failed to evidence case manager hapatient needs we speech therapist.  10. 06/2 medication and we case manager hapatient needs we speech therapist.	14/15: " Pt took  //c [sic] required to tuck  ing " The visit note  e that the physician and d been notified and re coordinated with a						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 57 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157653			COMP	LETED -//2015
NAME OF F	PROVIDER OR SUPPLIER		635	EET ADDRESS, CITY, STATE, ZIP COI 5 S STATE RD 67 OORESVILLE, IN 46158	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE
	Pt is continuing difficulty swallo potential d/t [due slow to progress out with what lith has nutritional das well " The evidence that the manager had been needs were coordinated with the following:  1. 05/05 reports increase food / meds " evidence that the manager had been needs were coordinated with the manager had been needs were coordinated and patic coordinated with 3. 05/15 difficulty progress.	ech slow, garbled (wet), to have weight loss and wing. Pt has met max e to] these barrier. Pt is and states he gets worn the he currently does. Pt efficits affecting progress e visit note failed to e physician and case en notified and patient dinated with a speech therapy notes indicated  5/15: " Pt [patient] coughing and choking on The visit note failed to e physician and case en notified and patient dinated with a speech en otified and patient dinated with a speech en to eating well " The to evidence that the see manager had been ent needs were a speech therapist.  1/15: " Pt having ssing due to decrease " The visit note failed				

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 58 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE COMPI <b>09/14</b>	
NAME OF PROVIDER OR SUPPLIER		635 8	ET ADDRESS, CITY, STATE, ZIP CODE S STATE RD 67 DRESVILLE, IN 46158	•	
PREFIX (EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	O BE	(X5) COMPLETION DATE
manager had bee	he physician and case n notified and patient linated with a speech				
confusion over prothickener. Pt was cream of wheat we therapy] pressuaspirate it and voo having increased " The visit not the physician and notified and paties coordinated with  5. 05/25 kitchen and finish coughing and spi The visit note fair physician and cas notified and paties coordinated with  6. 06/16 [continued] difficant choking. Pt weight and appears trength decrease to lack of nutrition [speech therapy]; " The visit note of the physician and cas notified and paties coordinated with	a speech therapist.  7/15: " Pt seated in hed with breakfast. Pt is tting in trash can"  led to evidence that the se manager had been				

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			ILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF F	PROVIDER OR SUPPLIER		•	635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	notified and pati coordinated with	ent needs were a speech therapist.					
	thickened orange with aspiration / note failed to evi and case manage	8/15: " Pt drank e juice and had difficulty coughing " The visit idence that the physician er had been notified and re coordinated with a					
	feeling well and choking" The evidence that the manager had been	2/15: " Reports not not eating due to e visit note failed to e physician and case en notified and patient dinated with a speech					
	feeling well with produce words a reports has not e color not good, v having diff [diffi due to decreased weak at this time failed to evidence case manager ha	5/15: " Pt reports not a diff [difficulty] to s pt is so weak. Pt aten in days Pt's skin very frail and weak. Pt culty] making progress nourishment. Pt is very e " The visit note e that the physician and d been notified and re coordinated with a					
		30/15: " Pt in kitchen g with encouragement.					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 60 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/14/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		į	635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	pt doing well IV fluids for sho visit. Pt still inc fatigue " The evidence that the manager had been needs were coordinated with the following:  1. 06/02 "Possible placen g/tube [gastrosted biggest concern consistency food secondary] swall she really doesn' Risk factors - swallowing and The visit note far physician had been concerns Pt is visit on 6/3. Star poor and not eat	lowing difficulties. He / It want g/tube placement pt [patient] has trouble then laying down " iled to evidence that the					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 61 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	ETED
		157653	B. W	ING		09/14/	2015
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUFFLIER			635 S S	STATE RD 67		
RN2U IN	С			MOORE	ESVILLE, IN 46158		
(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 APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	physician had be	een notified.					
	2. The Adminis	trator was interviewed on					
	09/14/15 at 11:4	5 AM. The					
	Administrator st	ated she vaguely					
	remembered the	patient and proceeded to					
	review the patien	nt's record. The					
	Administrator st	ated she had performed					
	the patient's admission. The						
	Administrator w	as not able to answer nor					
	explain why spe	ech therapy was not					
	involved in the patient's case when it was						
	ordered by the physician at discharge.						
	The Administrator stated the case						
		ed in the patient's case					
	_	agency. During this					
		istrator emailed and					
		cted therapy company					
		es for the coordinator to					
	return her phone	can.					
	3. On 09/14/15	at 1:53 PM_the					
		ad a return call from the					
		py company. The					
	Administrator ha						
		n the contracted therapy					
		1.5					
		ted that a speech therapist					
		et with the spouse in July					
		was declined due to the					
	patient was "too						
		ated the speech therapist					
	_	see the patient to make					
		judgment and the					
	Administrator st	ated she did not know					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 62 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/14/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	provided by Empaide / office work Employee N wro of therapy comp therapy], ST had times with no reconstruction [doctor] notified interviewed at the did not remember therapist was and the speech therapist was and the speech therapist was and the physician office day and time the the physician.  4. The complaint 09/14/15 at 2:40 stated that the paragivers were the patient would therapy. The constaff would notifie informed the off difficulty with secomplainant state family caregiver the patient was refor some of the secomplainant state themselves as specomplainant state themselves as specomplainant state themselves as specomplainant state themselves as specomplainant state.	note dated 03/26/15, was ployee N, a home health ker, during this time. It "According to [Name any] ST [speech a called numberous [sic] turn call to ST. Dr. It Employee N was as time and stated she for who the speech as he did not know who poist spoke with at the and did not know what is speech therapist notified the and family told upon admission that and family told upon admission that and be getting speech implainant stated that the sy the office often and fice of the patient's wallowing. The ed that they (patient and so) were not aware that not getting speech therapy staff portrayed seech therapists. The ed no one had called and it was any speech therapy						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 63 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157653	B. W			09/14/	2015
NAME OF I	PROVIDER OR SUPPLIEF	<b>\</b>			ADDRESS, CITY, STATE, ZIP CODE		
DNOLLIN	0				STATE RD 67		
RN2U IN	<u> </u>			MOORE	ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
TAG				TAG			DATE
	•	icated how he / she was by a therapist that					
		he and was discussing					
		The complainant stated					
	the patient had gotten so weak that he / she was now in a skilled nursing facility						
	receiving speech therapy.						
	receiving speech therapy.						
	5. Upon returning inside the agency at						
		Iministrator stated that					
	· · · · · · · · · · · · · · · · · · ·	pist was not provided by					
	the said therapy						
	communication note dated 03/26/15 that Employee N had provided / indicated, but the speech therapist was provided						
		therapy company.					
	unough unother	merupy company.					
	6. An undated p	oolicy titled					
	"Coordination of	f Client Services"					
	indicated, "All p	ersonnel furnishing					
	services shall ma	aintain a liaison to assure					
	that their efforts	are coordinated					
	effectively and s	support the objectives					
	outlined in the P	lan of Care. This may be					
	done through for	rmal care conferences;					
	maintaining con	plete, current Care					
	Plans; and writte	en and verbal interaction					
	The Primary 1	Nurse will assume					
	responsibility fo	r updating / changing the					
		ommunicating changes to					
		n twenty - four [24] hours					
	~	nference or changes.					
	_	rill be contacted when his					
	/ her approval fo						
	ı	-	1				

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 64 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO UILDING	NSTRUCTION  00	(X3) DATE COMPL		
		157653	B. W	ING		09/14/	2015
NAME OF P	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE TATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	CEDED BY FULL PREFIX GEACH CORRECTIVE ACRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		тЕ	(X5) COMPLETION DATE	
	necessary and to changes in client	alert physician to condition.					
	Manager" indicate with physicians, professionals [the services], clients developing a complan of care"  8. An undated professional of Client Services assessment, the answer of Therapis findings of the interest of Clinical manage personnel furnish maintain a liaison efforts are coord support the object Plan of Care. The formal care confict complete, current and verbal interest of the complete of the complete of the conference of will be contacted.	nprehensive, coordinated					
	_	nges in client condition.					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 65 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		157653	B. WING		09/14/2015		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
RN2U IN	С		635 S STATE RD 67 MOORESVILLE, IN 46158				
(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 APPROPRIAT			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	•	olicy titled Therapy					
		ed, " The therapist will					
	consult and colla						
	-	who is the case manager.					
	The therapist will participate in implementing the physician's plan of care						
and evaluating client progress "							
	10. An undated policy titled						
Occupational Therapy indicated, "							
	•	plans and changes to the					
	•	nursing Case Manager					
	and other Agency Staff through the care plan, written progress notes, and						
		eare conferences "					
	participation in c	are conferences					
G 0157	484.18				1		
	ACCEPTANCE O	F PATIENTS, POC, MED					
Bldg. 00	SUPER						
		oted for treatment on the able expectation that the					
		nursing, and social needs					
	•	ately by the agency in the					
	patient's place of r						
	Based on record	review and interview,	G 0157	1. Administrator/designee will	10/16/2015		
	the agency failed	I to ensure that the		complete a patient complaintform			
	patient / family o	caregivers were informed		when receiving a complaint.			
	in advance of the	e physician ordered		(On-going)  2. All complaint forms will be given			
	services and the	services that would be		to Administrator sameday to review	,		
	provided prior to	the start of care for 1 of		contact person(s) making complaint,			
	1 record reviewe			document conversation			
				andsign/date form. (On-going)			
	Findings include	ed:		3. Patient records requested to be			
	<i>G</i>			mailed will be mailedcertified mail			

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 66 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157653	B. W	NG		09/14/2015
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIE	R			STATE RD 67	
RN2U IN	С			MOORE	ESVILLE, IN 46158	
(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	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
					return receipt requested. (On-going	)
	1. Clinical reco	rd number 16 SOC (start			4. DON/designee will notify	
	of care) 03/19/1	5, included a plan of care			patient/family same day it	
	established by the	ne physician for the			isdetermined agency cannot provide a discipline. (On-going)	e
	certification per	iod of 03/19/15 to			5. DON/designee will notify MD	
		7/18/15 to 07/16/15, with			same day it is determinedagency	
		d nursing, home health			cannot provide a discipline.	
		_			(On-going)	
	aide, physical and occupational therapy.				6. DON/designee will review all	
	A 1: 1	C			admissions to ensure agencycan	
		rge summary from a			provide ordered disciplines and that	t
		facility dated 03/17/15,			all ordered disciplines are scheduled	d.
	indicated the par	tient had a past medical			(On-going)	
	history of aspiration pneumonia and				7. When agency uses a staffing	
	dysphagia. The physician's assessment				agency to cover a	
	indicated the pn	eumonia was resolved			disciplineDON/designee will tract al	
	but remains high				communications with the staffing	
	secondary to dy	•			agency to ensurethere is timely	
		nechanical soft diet with			follow up. (On-going)	
	_				8. When a staffing agency is used, DON/designee will contactstaffing	
		l liquids, and for patient /			agency daily, Mon-Fri, for	
	_	er to speech therapist with			coordination of care. All contact wil	1
		on on nectar thickened			bedocumented in the appropriate	
	_	nmary indicated the			patient's chart. (On-going)	
	patient was to be	e discharged home with			9. If patient/caregiver declines	
	speech therapy.				therapy services,DON/designee will	
					contact patient/family no later than	
	b. A signed	prescription dated			next business day toconfirm they	
		ated the patient was to be			declined therapy. Conversation will	
	1	e with speech therapy			be documented in	
	services.	c specen merupy			appropriatepatient's chart.	
	Selvices.				(On-going)	
	) The A.I				10. DON/designee will in-service	
		strator was interviewed on			professional on requirementto contact all disciplines involved in	
ı	09/14/15 at 11:4				patient's care and document name	
		tated she vaguely			ofperson spoke with along with date	e
	remembered the	patient and proceeded to			and time. (On-going)	

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  635 S STATE RD 67  RN2U INC  MOORESVILLE, IN 46158	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY	(X5) OMPLETION DATE
review the patient's record. The Administrator stated she had performed the patient's admission. The Administrator was not able to answer nor explain why speech therapy was not involved in the patient's case when it was ordered by the physician at discharge. The Administrator stated the case manager involved in the patient's case retired from the agency. During this time, the Administrator emailed and called the contracted therapy company and left messages for the coordinator to return her phone call.  3. On 09/14/15 at 1:53 PM, the Administrator had a return call from the contracted therapy company indicated that a speech therapist had made contact with the spouse in July but the services was declined due to the patient was "too far gone." The Administrator stated the speech therapist did not go out to see the patient to make that assessment / judgment and the Administrator stated she did not know who the speech therapist was. A communication note dated 03/26/15, was provided by Employee N, a home health aide / office worker, during this time. Employee N wrote "According to [Name of therapy company] ST [speech	

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 68 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO UILDING	00	COMPL		
		157653	B. W	ING		09/14	/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
RN2U IN	С				STATE RD 67 ESVILLE, IN 46158		
(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)	ATE	COMPLETION DATE
		called numberous [sic]					
	times with no ret	turn call to ST. Dr.					
	[doctor] notified	." Employee N was					
	interviewed at th	is time and stated she					
	did not remembe	er who the speech					
	therapist was and	d she did not know who					
	the speech therap	pist spoke with at the					
		and did not know what					
	day and time the	speech therapist notified					
	the physician.						
	4. The complain	ant was contacted on					
	09/14/15 at 2:40	PM. The complainant					
	stated that the pa	tient and family					
	caregivers were	told upon admission that					
	the patient would	d be getting speech					
	therapy. The co	mplainant stated that the					
	staff would notif	y the office often and					
	informed the off	ice of the patient's					
	difficulty with sv	wallowing. The					
	complainant stat	ed that they (patient and					
	_	s) were not aware that					
	the patient was r	ot getting speech therapy					
	for some of the s	staff portrayed					
	themselves as sp	eech therapists. The					
	complainant stat	ed no one had called and					
	left messages no	r was any speech therapy					
	services had bee						
	complainant indi	icated how he / she					
	discovered this v	vas by a therapist that					
	came to the hom	e and was discussing					
		. The complainant stated					
		otten so weak that he /					
	she was now in a	a skilled nursing facility					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 69 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	lì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/14/	ETED
NAME OF F	PROVIDER OR SUPPLIEF			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	IATE	(X5) COMPLETION DATE
	Admission Proces "Admission crites which a client ca for admission. To The Agency is needed care or so intensity the clie The services and current profession for the respective be reasonable and treatment of a made and suitability of not adequate to readmission profes information on the client / caregiver services, treatmen client / caregiver possible Upon admission of a c Registered Nurse the individual to professional If the required head will be made to the	olicy titled Client ess indicated, eria are standards by an be deemed appropriate These standards include is capable of providing the ervice at the level of ent's condition requires I care must conform with onal standards of practice the discipline and should defined in the following great and complexity of met by agency, Skills of agency personnel are meet client needs The dissional will verify all the one in the form with the ment and obtain input when					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 70 of 241

STATEMEN	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
		157653	B. W	ING	<del></del>	09/14/	
		<u> </u>		CTREET	ADDDECC CITY CTATE 7ID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE STATE RD 67		
RN2U IN	IC				ESVILLE, IN 46158		
(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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	will be notified	"					
G 0164 Bldg. 00	Agency professio	EW OF PLAN OF CARE nal staff promptly alert the changes that suggest a plan of care.					
	Based on record	review and interview,	G 0	164	Administrator/designee will		10/16/2015
	the agency faile	d to ensure that the			complete a patient complaint	form	
	physician was p	romptly notified of the			when receiving a complaint. (On-going)2. All complaint for	me	
		herapy services at the			will be given to Administrator	1115	
		notified of the patient's			sameday to review, contact		
		wallowing and weight			person(s) making complaint,		
	loss for 1 of 4 records reviewed. (#16)			document conversation			
	1088 101 1 01 4 16	colus leviewed. (#10)			andsign/date form. (On-going		
	Findings include	e:		Patient records requested mailed will be mailedcertification return receipt requested. (On-going)4. DON/designer notify patient/family same isdetermined agency camprovide a discipline. (On-gone) DON/designee will notify same day it is determined cannot provide a discipline.			
	of care), for cert to 05/17/15 and with orders for s	rd number 16, SOC (start ification period 03/19/15 05/18/15 to 07/16/15 skilled nursing, physical il therapy services.				y it g)5. ency	
	a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a history of aspiration pneumonia due to dysphagia and had been receiving speech therapy during his / her inpatient stay. This discharge summary had indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the				(On-going)6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and that all ordered disciplines are scheduled. (On-going)7. When agency uses a staffing agency to cover a disciplineDON/designee will tract all communications with the staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency is used, DON/designee will contactstaffing agency daily, Mon-Fri, for coordination of care. All contact	d ses ract e is ed, affing	

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

RNZU INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (15X STATE RD 67 MOORESVILLE, IN 46158  (RACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin" The visit note failed to evidence that the physician had been notified.  2. 04/17/15: " Instructed pt on ways to prevent aspiration and encourage patient to tuck in chin when		IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL 09/14/	ETED
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  2. 04/17/15: " Instructed pt on ways to prevent aspiration and					635 S S	TATE RD 67		
home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  2. 04/17/15: " Instructed pt on ways to prevent aspiration and	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
swallowing and using thickening with liquids " The visit note failed to evidence that the physician had been notified.  3. 04/20/15: " SN instructed pt on swallowing techniques, thickening of fluids " The visit note failed to		home. The agent physician of the speech therapy s  b. Review of notes indicated to the speech therapy s  b. Review of notes indicated to the speech therapy s  1. 04/08 nursing instruct [patient] tucking and drinking. Pt spell this morning SN had pt break take with ensure patient tuck in classified to evidence been notified.  2. 04/17 on ways to preve encourage patient swallowing and liquids " The evidence that the notified.  3. 04/20 pt on swallowing	cy failed to notify the inability to provide ervices.  If the skilled nursing he following:  8/15: " SN [skilled ed and reviewed with pt chin down when eating stated had coughing g while eating breakfast. multivitamin in half and while SN watched hin " The visit note e that the physician had  1/15: " Instructed pt ent aspiration and at to tuck in chin when using thickening with e visit note failed to e physician had been  1/15: " SN instructed g techniques, thickening			appropriate patient's chart. (On-going)9. If patient/caregiv declines therapy services,DON/designee will contact patient/family no later than next business day toconf they declined therapy. Conversation will be documen in appropriatepatient's chart. (On-going)10. DON/designee in-service professional on requirementto contact all disciplines involved in patient's care and document name ofperson spoke with along with date and time. (On-going)11. DON/designee will in-service son requirement tonotify MD of changes in patient's condition document in patient's condition document in patient's chart. (On-going)12. DON/designee ensure all disciplines involved inpatient's care will participate	irm ted will staff and will	

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 72 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
		157653	B. W	ING		09/14/	/2015
NAME OF F	PROVIDER OR SUPPLIEF	<b>\</b>	<u> </u>	1	DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C		635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID	T	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e physician had been					
	notified.						
	4 05/0	4/15: " Instructed pt					
		en drinking and eating					
		on hydration nutrition					
	_	of fluids " The visit					
		idence that the physician					
	had been notified	1 2					
	5. 06/30	0/15: " SN had pt eat					
	banana, glass of	OJ [orange juice] and ate					
	approx ½ bowl o	of cream of wheat then					
	started to have c	oughing spell, unable to					
	finish all of crea	m of wheat " The					
	visit note failed	to evidence that the					
	physician had be	een notified.					
l	6 Clail	ed nursing discharge					
		ted " Summary of					
	1	Date by Discharging					
		for eval and assess CV					
	_	/ Resp [respiratory] / GI					
	1	] / GU [geniturinary]					
	'0	uation] and assess					
	_	petite wgt [weight] loss					
	(failure to thrive	) Patient Condition at					
	Discharge: Prob	olems swallowing,					
	keeping food, lie	quids down, even					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 73 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	ghough using this weeks, 6 pounds Instructions: Co sm [small] freq [thought day. Dr daily with thicker failed to evidence been notified.  c. Occupation indicated the following of the companies	ickener. Wgt loss past 2  i Discharge Planning / ont to use thickening. Eat  frequent]meals snack ink at least 3 - 4 Ensure ener " The visit note be that the physician had  onal therapy notes lowing:  8/15: " Pt doing fair omplained of] difficulty  TR [Occupational ered] educated pt se] / daughter on need for se thickened liquids. Dtr she won't drink anything  * [* secondary] taste. ded premixed thickened			CROSS-REFERENCED TO THE APPROPRIA	TE		
	[and] thickener refailed to evidence been notified.  2. 04/25 pain in neck and	needs " The visit note that the physician had 5/15: " Pt reported						
	•	ed liquids after taking up meds in applesauce or						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 74 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	pudding and taki	ng small amounts of						
	•	ed taking a pill one day						
		back up the next day "						
		iled to evidence that the						
	physician had be	en notified.						
		2/15 note indicated pt was swallowing. The visit						
		idence that the physician						
	had been notified	* *						
		••						
	4. 05/12	2/15 note indicated the						
	patient was havin	ng difficulty swallowing						
	-	akness. The patient's						
	-	6 on a scale from one to						
	10 with 10 being	the worse. The patient						
	also had complain	ined of neck and throat						
	being sore, swall	lowing difficulties and						
	thick congestion	" The visit note						
	failed to evidence	e that the physician had						
	been notified.							
	5. 05/19	9/15: " Pain level 4/5						
	at the neck and t	hroat, decrease						
	endurance "	The visit note failed to						
	evidence that the	e physician had been						
	notified.							
	6. 05/21	1/15: " Pt continues to						

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL			
		157653	B. W	ING		09/14/	/2015	
NAME OF F	PROVIDER OR SUPPLIER	\ {		1	DDRESS, CITY, STATE, ZIP CODE	<u> </u>		
RN2U IN	C		635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-	his throat Discussed						
	•	atrition and drinking						
	_	able to swallow and						
	_	ar diet on any particular						
	-	sit note failed to evidence						
	that the physicia	n had been notified.						
	7 05/2	5/15. !! D4						
		5/15: " Pt required						
		swallowing food to tuck was running through						
		6 6						
		pt kept coughing and						
		ng up food. Pt was very						
	upset and would							
	•	nking ensure later due to						
		Pain to the neck at a						
		e visit note failed to						
		e physician had been						
	notified.							
	8 05/2	6/15: " When talking						
		orted he / she hadn't						
		e to being weak Pt						
	required mod [m	<del>-</del>						
		[sic] for tucking his / her						
		owing Pt able to keep						
		lay " The visit note						
		the that the physician had						
	been notified.	e mai me physician nau						
l	occii notifica.							
			1				ı	

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 76 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		l í	UILDING	NSTRUCTION  00	(X3) DATE COMPL 09/14/	ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPF DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
TAG	9. 6/11/ waking up early he was unable to stated [illegible of to drink three en required to tuck required extra tin with swallowing to evidence that notified.  10. 06/2 medication and of chin on swallow failed to evidence been notified.  11. 06/2 difficulty Spec Pt is continuing difficulty swallo potential d/t [due slow to progress out with what lit has nutritional de as well " The	and having breakfast but keep it down Pt writing] for told him / her sures a day v/c [sic] chin to swallow. Pt me to eat due to problems The visit note failed the physician had been  [14/15: " Pt took w/c [sic] required to tuck ing " The visit note e that the physician had  [19/15: " Swallowing each slow, garbled (wet), to have weight loss and wing. Pt has met max e to] these barrier. Pt is and states he gets worn the he currently does. Pt efficits affecting progress e visit note failed to e physician had been		TAG	DEFICIENCY)		DATE	

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 77 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			LDING	NSTRUCTION  00	(X3) DATE : COMPL <b>09/14</b> /	ETED			
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	d. Physical the following:	therapy notes indicated							
	reports increase food / meds evidence that the notified.	5/15: " Pt [patient] coughing and choking on " The visit note failed to e physician had been  7/15: " Pt reports have							
	lost weight and i	not eating well " The iled to evidence that the							
	difficulty progre	1/15: " Pt having ssing due to decrease ke " The visit note that the physician had							
	confusion over p thickener. Pt wa cream of wheat w therapy] pres aspirate it and vo having increased	4/15: " Pt reports preparation of food with as finishing bowl of when PT [physical sent. He / she appeared to pomited it all back up. Pt al difficulty with nutrition pote failed to evidence that d been notified.							

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION  00	COMPL		
		157653	B. W	ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67				
RN2U IN	С				ESVILLE, IN 46158		
(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)	ATE	(X5) COMPLETION DATE
	5. 05/25 kitchen and finis coughing and sp The visit note fa physician had be  6. 06/16 [continued] diffi and choking. Pt weight and appe strength decrease to lack of nutritic [speech therapy] " The visit no the physician ha  7. 06/18 thickened orange with aspiration / note failed to evi had been notified  8. 06/25 feeling well and choking " Th	5/15: " Pt seated in shed with breakfast. Pt is itting in trash can " illed to evidence that the een notified.  6/15: " Pt reports cont culty with swallowing appears to have lost ars malnourished Pt's ed slightly possibly due on Speech: See ST; Swallowing: See ST ote failed to evidence that ad been notified.  8/15: " Pt drank e juice and had difficulty coughing" The visit idence that the physician					

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ILTIPLE CO. ILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157653	B. WIN			09/14/		
NAME OF F	PROVIDER OR SUPPLIER		<del>'</del>	STREET A	DDRESS, CITY, STATE, ZIP CODE			
RN2U IN			635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID		TATEMENT OF DEFICIENCIES	$oldsymbol{\perp}$	ID I			(V5)	
PREFIX		CY MUST BE PRECEDED BY FULL	]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		5/15: " Pt reports not						
	_	n diff to produce words as						
	-	t reports has not eaten in						
	_	color not good, very frail						
		ving diff [diffiuclty]						
		due to decreased						
		is very weak at this time						
		ote failed to evidence that						
	the physician ha	d been notified.						
		30/15: " Pt in kitchen						
		g with encouragement.						
		with eating / swallowing						
	-	and presents better after						
		rt ER [emergency room]						
		rease weakness and						
	_	e visit note failed to						
		e physician had been						
	notified.							
	- Casial							
		ork visit notes indicated						
	the following:							
	1. 06/03	3/15: Reason for visit:						
		nent: Assisted Living,						
	_	omy tube] His / her						
		is having to eat nectar						
	consistency food	•						
	-	lowing difficulties. He /						
	23							

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 80 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BI B. W		00		
		157653	D. W		-	09/14/	2015
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				TATE RD 67 ESVILLE, IN 46158		
					LOVILLE, IIV 40100	ı	715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	L LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	she really doesn'	't want g/tube placement					
	Risk factors -	pt [patient] has trouble					
	swallowing and	then laying down "					
	The visit note fa	iled to evidence that the					
	physician had be	een notified.					
	2. 06/24	4/15: Reason for visit:					
	"Assisting with	g/tube placement					
	concerns Pt is	visibly smaller since last					
	visit on 6/3. Sta	tes his energy level is					
	poor and not eat	ing well at all " The					
	1 ^	to evidence that the					
	physician had be						
	1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7						
	2. The Adminis	trator was interviewed on					
	09/14/15 at 11:4	5 AM. The					
	Administrator st	ated she vaguely					
	remembered the	patient and proceeded to					
	review the patien	nt's record. The					
	_	ated she had performed					
	the patient's adm	nission. The					
	Administrator w	as not able to answer nor					
	explain why spe	ech therapy was not					
	involved in the p	patient's case when it was					
	ordered by the p	hysician at discharge.					
		for stated the case					
	manager involve	ed in the patient's case					
	_	agency. During this					
		istrator emailed and					
		cted therapy company					
		es for the coordinator to					
	return her phone						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 81 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/14	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	contracted theray Administrator had coordinator from company indicate had made contact but the services patient was "too Administrator st did not go out to that assessment Administrator st who the speech communication provided by Employee N wro of therapy comp therapy], ST had times with no re [doctor] notified interviewed at the did not remember therapist was another speech therapy physician office day and time the the physician.  4. An undated pindicated, "Profee	and a return call from the py company. The and stated that the in the contracted therapy and that a speech therapist at with the spouse in July was declined due to the far gone." The atted the speech therapist a see the patient to make a judgment and the atted she did not know therapist was. A mote dated 03/26/15, was ployee N, a home health ker, during this time.						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 82 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUIL B. WING	DING	00	COMPL 09/14/	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
G 0176 Bldg. 00	changes that sug Plan of Care "  5. An undated p Therapy indicate plans and change nursing Case Ma Staff through the progress notes, a conferences "  484.30(a) DUTIES OF THE Interegistered nur progress notes, conforms the physic changes in the paraneeds. Based on record the agency failed Registered Nurse physician and conspeech therapist difficulty to swall 1 of 4 records refindings include 1. Clinical record of care), for certification of care of sand occupational	gest a need to alter the  colicy titled Occupational ad, " Communicates as to the physician and to anager and other Agency acare plan, written and participation in care  REGISTERED NURSE as prepares clinical and acordinates services, ain and other personnel of attent's condition and  review and interview, at to ensure that the achad notified the acordinated services with a ain relation to a patient's allow and weight loss for aviewed. (#16)	G 017		1. Administrator/designee will complete a patient complaints when receiving a complaint. (On-going)2. All complaint form will be given to Administrator sameday to review, contact person(s) making complaint, document conversation and sign/date form. (On-going)? Patient records requested to be mailed will be mailed certified in return receipt requested. (On-going)4. DON/designee we notify patient/family same day isdetermined agency cannot provide a discipline. (On-going DON/designee will notify MD same day it is determined agency cannot provide a discipline.	3. e nail iil it )5.	10/16/2015	
	•	14/15. The discharge			(On-going)6. DON/designee w review all admissions to ensure			

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 83 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157653	B. WING 09/14/2015			09/14/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				STATE RD 67	
RN2U IN	С				ESVILLE, IN 46158	
(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 APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		skilled nursing facility			agency canprovide ordered disciplines and that all ordered	
	dated 03/17/15, i	indicated the patient had			disciplines are scheduled.	
	a history of aspir	ration pneumonia due to			(On-going)7. When agency us	es
	' ' '	ad been receiving speech			a staffing agency to cover a disciplineDON/designee will tra	act
	therapy during h	is / her inpatient stay.			all communications with the	
	The summary als	so indicated that the			staffing agency to ensurethere timely follow up. (On-going)8.	is
	patient was being	g discharged from home			When a staffing agency is use	
	with speech there	apy as a physician order			DON/designee will contactstaf	fing
	dated 03/17/15 in	ndicated as such.			agency daily, Mon-Fri, for coordination of care. All contact	et l
					will bedocumented in the	
	h Review o	of the skilled nursing			appropriate patient's chart.	
		Č			(On-going)9. If patient/caregive	er
	notes indicated the	ne following.			declines therapy services,DON/designee will	
					contact patient/family no later	
		8/15: " SN [skilled			than next business day toconfi	rm
	nursing] instruct	ed and reviewed with pt			they declined therapy.  Conversation will be documen	tod
	[patient] tucking	chin down when eating			in appropriatepatient's chart.	ieu
	and drinking. Pt	stated had coughing			(On-going)10. DON/designee	will
	spell this mornin	g while eating breakfast.			in-service professional on requirementto contact all	
	SN had pt break	multivitamin in half and			disciplines involved in patient's	5
	take with ensure	while SN watched			care and document name	
	patient tuck in ch	nin " The visit note			ofperson spoke with along with date and time. (On-going)11.	'
	failed to evidenc	e that the physician had			DON/designee will in-service s	
	been notified and	d patient needs were			on requirement tonotify MD of changes in patient's condition	
	coordinated with	a speech therapist.			document in patient's chart.	
					(On-going)12. DON/designee	will
	2. 04/17	7/15: " Instructed pt on			ensure all disciplines involved inpatient's care will participate	in
		aspiration and encourage			case conference. (On-going)	
	1 1	chin when swallowing				
	1 *	ning with liquids "				
	and using uncker	ning with fiquids				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING 00  B. WING		COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RN2U IN	С			STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The visit note fai	led to evidence that the			
	physician had be	en notified and patient			
	needs were coord	dinated with a speech			
	therapist.				
	3. 04/20 on swallowing to fluids " The verified and patience that the notified and patience oordinated with 4. 05/04 thin tuck when dinstructed pt on I thickening of fluid failed to evidence been notified and	20/15: " SN instructed pt echniques, thickening of visit note failed to a physician had been ent needs were a speech therapist.  21/15: " Instructed pt on rinking and eating SN mydration nutrition and ids" The visit note e that the physician had a speech therapist.			
		7/15: " SN instructed pt			
		ove swallowing tuck in			
	•	g meds [medications]			
		The visit note failed to			
		physician had been			
	notified and patie				
	coordinated with	a speech therapist.			
	6. 05/15	5/15: Recertification			

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	JILDING	00	COMPL	
		157653	B. W	_		09/14/	2015
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				STATE RD 67 ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY 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 APPROPRIATE DEFICIENCY)		DATE
	reassessment ind	licated the patient had a					
	functional limita	ation of swallowing,					
	safety measures	/ precautions of					
	aspiration and th	nat. Physical and					
	occupational the	rapy was on hold for					
	re-evaluation aft	er the speech therapist					
	was to help with	swallowing, increase					
	nutrition, and inc	crease strength. The					
	patient was recei	rtified to home health					
	care with skilled	l nursing, aide and speech					
	therapy. The skilled nurse instructed and						
	reviewed with patient ways to help						
	decrease aspirati	ion. The skilled nurse					
	educated patient	/ family on dosage of					
	thick it [powder	substance to be added to					
	fluids to increase	e thickness] to be placed					
	in liquids. Recer	tification Summary					
	indicated the pat	tient's appetite has been					
	decreased and sp	beech therapy was to see					
	-	vallowing concerns. The					
	skilled nurse ind	_					
	coordinated with	n physician, physical,					
		d speech therapy but did					
	_	the clinicians were.					
	7. 06/30	0/15: " SN had pt eat					
		OJ [orange juice] and ate					
	, 0	of cream of wheat then					
		oughing spell, unable to					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 86 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	l í	JILDING	nstruction 00	(X3) DATE COMPL 09/14/	ETED
NAME OF F	PROVIDER OR SUPPLIER		<u>'</u>	635 S S	NDDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158	•	
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		m of wheat pt to warm					
		about an hour and try to					
		risit note failed to					
		e physician had been					
		patient needs were					
	coordinated with	a speech therapist.					
	8 Skill	ed nursing discharge					
		ed " Summary of Care					
	Provided to Date by Discharging						
	Discipline: SN for eval [evaluation] and						
	•	ent CV [cardiovascular] /					
	-	y] / GI [gastrointestinal] /					
	GU [genitourina						
	[evaluation] and	assess [assessment]					
	appetite wgt [we	ight] loss (failure to					
	thrive) Patient	Condition at Discharge:					
	Problems swallo	wing, keeping food,					
	liquids down, ev	en though using					
	thickener. Wgt l	oss past 2 weeks, 6					
	pounds Discha	arge Planning /					
	Instructions: Co	nt [continue] to use					
	thickening. Eat	sm [small] freq					
	[frequent] meals	snack thought day.					
		4 Ensure daily with					
	thickener " T	he visit note failed to					
	evidence that the	e physician had been					
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 87 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	ì	JETIPLE CO ILDING	NSTRUCTION 00	COMPL	
		157653	B. WI	NG		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 SVILLE, IN 46158		
(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 DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	2. The Administ	rator was interviewed on					
	09/14/15 at 11:4	5 AM. The					
Administrator stated she vaguely							
	remembered the	patient and proceeded to					
	review the paties	nt's record. The					
	Administrator stated she had performed						
	the patient's admission. The						
	Administrator was not able to answer nor						
	explain why speech therapy was not						
	involved in the p	patient's case when it was					
	ordered by the p	hysician at discharge.					
	The Administrat	or stated the case					
	manager involve	ed in the patient's case					
	retired from the	agency.					
	3. An undated p	policy titled					
	_	f Client Services"					
	indicated, "All p	ersonnel furnishing					
	_	aintain a liaison to assure					
	that their efforts	are coordinated					
	effectively and s	support the objectives					
	outlined in the P	lan of Care. This may be					
	done through for	rmal care conferences;					
	maintaining con	nplete, current Care					
	Plans; and writte	en and verbal interaction					
	The Primary 1	Nurse will assume					
	responsibility fo	r updating / changing the					
	Care Plan and co	ommunicating changes to					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 88 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157653		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  IG 00	(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		635	EET ADDRESS, CITY, STATE, ZIP CODE 5 S STATE RD 67 OORESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
G 0184 Bldg. 00	following the control The physician work of her approval for necessary and to changes in clients.  4. An undated physicians, professionals [the services], clients developing a complan of care "  484.32 THERAPY SERVICE Based on record the agency failed qualified therapicy within their scoperecords reviewed ensure that physicians are manager of swallow and weir records reviewed to ensure that a proordinating service that a proordinating servic	alert physician to condition.  condition.  colicy titled "RN Case ted," Collaborates other health care erapists supportive , and families in imprehensive, coordinated  CES  review and interview, I to ensure that a st was providing services e of practice for 1 of 4 I (See G 185); failed to ical and occupational fied the physician and a patient's difficulty to ght loss for 1 of 4 I (See G 186); and failed batient needs were met by vices with a speech	G 0184	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be give to Administrator sameday to revicontact person(s) making compladocument conversation and sign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mareturn receipt requested. (On-going) 4. DON/designee will notify patient/family same day it isdetermined agency cannot prova a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency	en iew, iint, e ail ing)

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 89 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	00	(X3) DATE SURVEY  COMPLETED				
		157653	B. WING	00	09/14/2015			
			STREE	ET ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIE	R	635 S STATE RD 67					
RN2U IN	С			RESVILLE, IN 46158				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)			
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE DATE			
		,		cannot provide a discipline.				
	The cumulative	effect of this systemic		(On-going)				
		d in the agency being out		6. DON/designee will review a	п			
	1 ^	with the Condition of		admissions to ensure agency				
	_			canprovide ordered discipline	s and			
	Participation 484	4.32 Therapy Services.		that all ordered disciplines are				
				scheduled.(On-going)				
				7. When agency uses a staffing	g			
				agency to cover a				
				disciplineDON/designee will tr				
				communications with the staf	-			
				agency to ensurethere is time	ly			
				follow up. (On-going)				
				8. When a staffing agency is us				
				DON/designee will contactstate agency daily, Mon-Fri, for	ning			
				coordination of care. All conta	ct will			
				bedocumented in the appropr				
				patient's chart. (On-going)				
				9. If patient/caregiver declines	5			
				therapy services,DON/designe				
				contact patient/family no late	r than			
				next business day toconfirm the	ney			
				declined therapy. Conversatio	n will			
				be documented in				
				appropriatepatient's chart.				
				(On-going)				
				10. DON/designee will in-servi				
				professional on requirements				
				contact all disciplines involved				
				patient's care and document r ofperson spoke with along wit				
				and time. (On-going)	inuate			
				11. DON/designee will in-servi	ice			
				staff on requirement tonotify				
				changes in patient's condition				
l				document in patient's chart.				
				(On-going)				
				12. DON/designee will ensure	all			
				disciplines involved inpatient's	s care			

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 90 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	COMPLETED	
		157653	B. WI	NG		09/14/	/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				STATE RD 67			
RN2U IN	C.				ESVILLE, IN 46158			
				<u> </u>	1000			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE	
					will participate in case conference.			
					(On-going)			
G 0185	484.32							
0 0 100	THERAPY SERVI	CES						
Bldg. 00		ces offered by the HHA						
ŭ	directly or under a	rrangement are given by a						
		or by a qualified therapy						
		e supervision of a qualified						
	•	ccordance with the plan of						
	care.	raviaw and interview	G 0	105			10/16/2015	
		review and interview,	100	183	1. Administrator/designee will		10/10/2013	
	the agency failed				complete a patient complaintform			
		st was providing services			when receiving a complaint.			
	•	e of practice for 1 of 4			(On-going)			
	records reviewed	l.			2. All complaint forms will be given			
					to Administrator sameday to review	,		
	Findings include	:			contact person(s) making complaint	,		
	-				document conversation			
	1. Clinical recor	rd number 16, SOC (start			andsign/date form. (On-going)			
	of care), for certi	fication period 03/19/15			3. Patient records requested to be			
	* *	05/18/15 to 07/16/15.			mailed will be mailedcertified mail			
					return receipt requested. (On-going	)		
	a A dischar	ge summary from a			4. DON/designee will notify			
					patient/family same day it isdetermined agency cannot provide			
	•	acility dated 03/17/15,			a discipline. (On-going)	=		
	-	ient had a past medical			5. DON/designee will notify MD			
		tion pneumonia and			same day it is determinedagency			
		physician's assessment			cannot provide a discipline.			
	indicated the pne	eumonia was resolved			(On-going)			
	but remains high	aspiration risk			6. DON/designee will review all			
	secondary to dys	phagia. Diet at			admissions to ensure agencycan			
	discharge was m	echanical soft diet with			provide ordered disciplines and that			
	•	liquids, and for patient /			all ordered disciplines are scheduled	l.		
		r to speech therapist with			(On-going)			
		n on nectar thickened			7. When agency uses a staffing			
					agency to cover a	ı		
	nquius. The sun	nmary indicated the			disciplineDON/designee will tract all			

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 91 of 241

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLETED
		157653	B. W	ING		09/14/2015
N	NOVEMBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	I
NAME OF F	PROVIDER OR SUPPLIEF	<b>K</b>			STATE RD 67	
RN2U IN	C			MOORE	ESVILLE, IN 46158	
(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 DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	_	e discharged home with			communications with the staffing agency to ensurethere is timely	
	speech therapy.				follow up. (On-going)	
					8. When a staffing agency is used,	
	_	prescription dated			DON/designee will contactstaffing	
	03/17/15, indicated the patient was to be				agency daily, Mon-Fri, for	
	discharged home with speech therapy				coordination of care. All contact wil	I
	services.				bedocumented in the appropriate	
	c. Occupational therapy notes indicated the following:				patient's chart. (On-going)	
					9. If patient/caregiver declines therapy services, DON/designee will	
					contact patient/family no later than	
					next business day toconfirm they	
	1. 04/08/15: " Pt doing fair				declined therapy. Conversation will	
	today. Pt c/o [co	omplained of difficulty			be documented in	
		R [Occupational			appropriatepatient's chart.	
					(On-going)	
	1	ered] educated pt			10. DON/designee will in-service professional on requirementto	
	[patient] / [spous	se] / daughter on need for			contact all disciplines involved in	
	pt [patient] to us	e thickened liquids. Dtr			patient's care and document name	
	[daughter] states	he won't drink anything			ofperson spoke with along with dat	e
	with thickener 2	* [* secondary] taste.			and time. (On-going)	
	OTR recommen	ded premixed thickened			11. DON/designee will in-service staff on requirement tonotify MD or	f
	liquids Teach	•			changes in patient's condition and	
	_	nnique - chin tuck &			document in patient's chart.	
		•			(On-going)	
	[and] thickener i	iccus			12. DON/designee will ensure all	
					disciplines involved inpatient's care will participate in case conference.	
	2. 04/2:	5/15: " Pt reported pain			(On-going)	
	in neck and trou	ble with swallowing.				
	Educated patient	t on drinking thickened				
	liquids after taki	ng bites of crushed up				
	meds in applesar	uce or pudding and				
	taking small am	ounts of meds. Pt				
	_	a pill one day and				

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL	
		157653	B. W	ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RN2U IN			635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID	,	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	coughing it back	up the next day "					
	3 05/2	1/15: " Pt continues to					
complain about his throat Discussed							
	_	atrition and drinking					
	_	able to swallow and					
	_	ar diet on any particular					
	day"						
	4. 05/25/15: " Pt required max						
	u/c [sic] for swallowing food to tuck his						
	chin. Pt nose wa	as running through entire					
	meal and pt kept	coughing and spitting /					
	throwing up foo	d. Pt was very upset and					
	wouldn't finish f	ood "					
	- 0-10	2/4 <b>2</b>					
		6/15: " When talking to					
	1 -	ted he / she hadn't eaten					
		ing weak Pt required / max [maximum] v/c					
	]	his /her chin when					
		t able to keep food down					
	this day "	dole to keep food down					
	tins day						
	9. 6/11/	15: " He reported					
		and having breakfast but					
		keep it down Pt					
	stated [illegible	writing] for told him /					
	her to drink three	e ensures a day v/c					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 93 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/14/2015		
NAME OF P	ROVIDER OR SUPPLIER		635 S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	N
		tuck chin to swallow. Pt me to eat due to problems				
	with swallowing	•				
		14/15: " Pt took v/c [sic] required to tuck ing "				
		trator was interviewed on PM. The Administrator				
	indicated she vaguely remembers the patient and proceded to look through the patient's record. The Adminstrator					
	notified the thera	apy company several to an agent at the therapy				
	company. Acco					
	_	rapist had attempted to e but was unsuccessful in				
	-	nily. Then at 2:30 PM,				
	remembered that	t the speech therapist was				
		npany she had contracted explain the lack of notes				
	and communicat	ion.				
	Therapy indicate occupational the	olicy titled Occupational ed, " Performs rapy assessments, skilled treatments, and				

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 94 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING OO COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED  B. WING 09/14/2015		
		157653	_		09/14/2015
NAME OF	PROVIDER OR SUPPLIE	R		STATE RD 67	
RN2U IN	IC		MOORESVILLE, IN 46158		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, and the second	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC I)	DATE
	0 0	tion of clients who are			
		es under a medically			
	approved Plan o	of Care "			
G 0186	484.32				
	THERAPY SERV				
Bldg. 00	•	rapist assists the physician patient's level of function,			
	_	p the plan of care (revising			
	it as necessary.)	p are plan or care (reviewig			
	Based on record	d review and interview,	G 0186	1. Administrator/designee will	10/16/2015
	the agency faile	ed to ensure that physical		complete a patient complaintform	
	and occupationa	al therapy had notified the		when receiving a complaint.	
		ase manager of a patient's		(On-going)	
	1 ^ -	allow and weight loss for		All complaint forms will be given     to Administrator sameday to review	,
	1 of 4 records re	•		contact person(s) making complaint	
		,		document conversation	,
	Findings includ	e:		andsign/date form. (On-going)	
				3. Patient records requested to be	
	1 Clinical reco	ord number 16, SOC (start		mailed will be mailedcertified mail	
		tification period 03/19/15		return receipt requested. (On-going 4. DON/designee will notify	(3)
		05/18/15 to 07/16/15		patient/family same day it	
		skilled nursing, physical		isdetermined agency cannot provid	e
		al therapy services.		a discipline. (On-going)	
		ar energy services.		5. DON/designee will notify MD	
	a A discha	arge summary from a		same day it is determinedagency	
		facility dated 03/17/15,		cannot provide a discipline.	
	1	tient had a past medical		(On-going) 6. DON/designee will review all	
	_	ation pneumonia and		admissions to ensure agencycan	
	1 .	e physician's assessment		provide ordered disciplines and tha	t
		neumonia was resolved		all ordered disciplines are schedule	
	_	h aspiration risk		(On-going)	
	1	rsphagia. Diet at		7. When agency uses a staffing	
	1	spnagia. Diet at nechanical soft diet with		agency to cover a	
ı	i discharge was n	nechanicai son diet with	Ī	disciplineDON/designee will tract al	I I

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 95 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO		COMPL	ETED	
		157653			09/14/	2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
TAINZO IIN	<u> </u>			WOOK			
(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
	nectar thickened	liquids, and for patient /			communications with the staffing		
	caregiver to refe	r to speech therapist with			agency to ensurethere is timely		
	more information on nectar thickened				follow up. (On-going)		
	liquids. The summary indicated the				8. When a staffing agency is used,		
	•	e discharged home with			DON/designee will contactstaffing		
	speech therapy.				agency daily, Mon-Fri, for coordination of care. All contact will	ı	
	speccii merapy.				bedocumented in the appropriate	'	
	b. A signed prescription dated				patient's chart. (On-going)		
					9. If patient/caregiver declines		
	03/17/15, indicated the patient was to be				therapy services, DON/designee will		
	_	with speech therapy			contact patient/family no later than		
	services.				next business day toconfirm they		
					declined therapy. Conversation will		
	<ul> <li>c. Occupation</li> </ul>	onal therapy notes			be documented in		
	indicated the foll	lowing:			appropriatepatient's chart.		
					(On-going)		
	1 04/08	8/15: " Pt doing fair			10. DON/designee will in-service		
					professional on requirementto		
	•	omplained of] difficulty			contact all disciplines involved in		
	swallowing. OT	•			patient's care and document name ofperson spoke with along with date	9	
	1 0	ered] educated pt			and time. (On-going)		
	[patient] / [spous	se] / daughter on need for			11. DON/designee will in-service		
	pt [patient] to us	e thickened liquids. Dtr			staff on requirement tonotify MD of		
	[daughter] states	he won't drink anything			changes in patient's condition and document in patient's chart.		
	with thickener 2	* [* secondary] taste.			(On-going)		
		ded premixed thickened			12. DON/designee will ensure all		
		•			disciplines involved inpatient's care		
	liquids Teachi	e e			will participate in case conference.		
	Swallowing tech	nique - chin tuck &			(On-going)		
	[and] thickener r	needs " The visit note					
		e that the physician and					
	case manager ha	d been notified and					
	patient needs we	re coordinated with a					
	speech therapist.						
	specon morupist.						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	JETIPLE CO ILDING	NSTRUCTION 00	COMPL			
		157653	B. WI	NG		09/14	/2015	
NAME OF F	PROVIDER OR SUPPLIER	<b>\</b>			DDRESS, CITY, STATE, ZIP CODE	<u> </u>		
RN2U IN	C		635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	2 04/2	5/15 " D 1						
		5/15: " Pt reported pain						
		ble with swallowing.						
	1	t on drinking thickened ng bites of crushed up						
	1	uce or pudding and						
	1	ounts of meds. Pt						
	l	a pill one day and						
	'	t up the next day "The						
		to evidence that the						
		ase manager had been						
	notified and pati	-						
	1	a speech therapist.						
		1						
	3. 04/22	2/15 note indicated pt was						
	having difficulty	swallowing. The visit						
	note failed to ev	idence that the physician						
	and case manage	er had been notified and						
	patient needs we	ere coordinated with a						
	speech therapist.							
	4. 05/12	2/15 note indicated the						
	l <sup>-</sup>	ng difficulty swallowing						
	1	akness. The patient's						
	1 ^	6 on a scale from one to						
	I -	g the worse. The patient						
	_	ined of neck and throat						
	_	lowing difficulties and						
	thick congestion	" The visit note						

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO ЛLDING	NSTRUCTION 00	(X3) DATE COMPL				
		157653	B. WI			09/14/			
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
RN2U IN			635 S STATE RD 67 MOORESVILLE, IN 46158						
(X4) ID	T	TATEMENT OF DEFICIENCIES	1	ID			(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
		te that the physician and							
		d been notified and							
	_	ere coordinated with a							
	speech therapist.								
	5 05/19	9/15: " Pain level 4/5							
	at the neck and t								
		The visit note failed to							
		at the physician and case							
		en notified and patient							
	1	dinated with a speech							
	therapist.								
	6. 05/2	1/15: " Pt continues to							
	complain about 1	his throat Discussed							
	importance of nu	atrition and drinking							
	ensure if pt is un	able to swallow and							
	cannot eat regula	ar diet on any particular							
	*	it note failed to evidence							
	1	n and case manager had							
		d patient needs were							
	coordinated with	a speech therapist.							
	7 05/24	5/15: " Pt required max							
		llowing food to tuck his							
		as running through entire							
		coughing and spitting /							
		d. Pt was very upset and							
		food. Discussed pt							
		1							

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 98 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF I	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE TATE RD 67	•	
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
	drinking ensure	later due to lack of					
	nutrients Pain	to the neck at a level 5					
	" The visit no	te failed to evidence that					
		d case manager had been					
	notified and pati						
	coordinated with	a speech therapist.					
	pt he / she report all day due to be mod [moderate] [sic] for tucking swallowing Pt this day " The evidence that the manager had bee	6/15: " When talking to ted he / she hadn't eaten sing weak Pt required / max [maximum] v/c his /her chin when table to keep food down to e visit note failed to be physician and case ten notified and patient dinated with a speech					
	waking up early he was unable to	/15: " He reported and having breakfast but keep it down Pt writing] for told him /					
		e ensures a day v/c					
		tuck chin to swallow. Pt					
		me to eat due to problems					
	-	g " The visit note					
	_	ee that the physician and					
		d been notified and					
	· ··· <b>¿</b> · · ····						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 99 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í		NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157653	A. BU B. W	UILDING ING	00	COMPLI 09/14/2	
		107000	2. ,,		ADDRESS, CITY, STATE, ZIP CODE	09/14/	2013
NAME OF I	PROVIDER OR SUPPLIEF	R			TATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	patient needs we	ere coordinated with a					
	speech therapist						
	aparam manipus						
	10. 06/14/15: " Pt took						
	medication and	v/c [sic] required to tuck					
	chin on swallow	ring " The visit note					
	failed to evidence	ce that the physician and					
	case manager ha	nd been notified and					
	patient needs we	ere coordinated with a					
	speech therapist.						
	11. 06/	19/15: " Swallowing					
	difficulty Spe	ech slow, garbled (wet),					
	Pt is continuing	to have weight loss and					
	difficulty swallo	owing. Pt has met max					
	potential d/t [due	e to] these barrier. Pt is					
	slow to progress	and states he gets worn					
	out with what lit	ttle he currently does. Pt					
	has nutritional d	eficits affecting progress					
	as well " The	e visit note failed to					
	evidence that the	e physician and case					
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
	d. Physical	therapy notes indicated					
	the following:						
	1. 05/0	5/15: " Pt [patient]					
	reports increase	coughing and choking on					
	food / meds "	' The visit note failed to					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 100 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL			
		157653	B. WI	ING		09/14/	2015	
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
			635 S STATE RD 67 MOORESVILLE, IN 46158					
RN2U IN				<u> </u>	ESVILLE, IN 46158			
(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)	ATE	DATE	
	evidence that the	physician and case						
	manager had bee	en notified and patient						
	needs were coor	dinated with a speech						
	therapist.							
		7/15: " Pt reports have						
		not eating well " The						
	visit note failed	to evidence that the						
		se manager had been						
	notified and pati							
	coordinated with	a speech therapist.						
		1/15: " Pt having						
		ssing due to decrease						
		" The visit note failed						
		the physician and case						
	_	en notified and patient						
		dinated with a speech						
	therapist.							
	4 05/1/	4/15: " Pt reports						
		reparation of food with						
	•	s finishing bowl of						
		when PT [physical						
		sent. He / she appeared to						
		omited it all back up. Pt						
	•	difficulty with nutrition						
	•	ote failed to evidence that						
		d case manager had been						
	me paysician and							

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 101 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	COMPL			
		157653	B. W			09/14		
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
RN2U IN			635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID	•	TATEMENT OF DEFICIENCIES		ID	-SVILLE, IIN 40130		(V.5)	
PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	VTE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·	DATE	
	notified and pati							
	coordinated with	a speech therapist.						
	- 0-10							
		5/15: " Pt seated in						
		shed with breakfast. Pt is						
		itting in trash can " iled to evidence that the						
	notified and pati	se manager had been						
	_	a speech therapist.						
	coordinated with	i a specen merapist.						
	6. 06/10	6/15: " Pt reports cont						
	difficulty with sv	wallowing and choking.						
	Pt appears to have	ve lost weight and						
	appears malnour	rished Pt's strength						
	decreased slightl	ly possibly due to lack of						
	nutrition Spee	ch: See ST [speech						
	therapy]; Swallo	wing: See ST " The						
	visit note failed	to evidence that the						
		se manager had been						
	notified and pati							
	coordinated with	a speech therapist.						
	7 06/19	8/15: " Pt drank						
		e juice and had difficulty						
		coughing " The visit						
	note failed to evi							
		se manager had been						
	notified and pati	<del>-</del>						

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. W	ING		09/14/	/2015
NAME OF F	PROVIDER OR SUPPLIER	<u>.                                    </u>	•		DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(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		a speech therapist.		TAG	DEFICIENCY)		DATE
	coordinated with	i a specen therapist.					
	8. 06/22	2/15: " Reports not					
	feeling well and	not eating due to					
	choking" The	e visit note failed to					
	evidence that the	e physician and case					
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
	0. 06/24	5/15: " Pt reports not					
		n diff [difficulty] to					
		s pt is so weak. Pt					
	l <sup>-</sup>	aten in days Pt's skin					
	_	very frail and weak. Pt					
		iuclty] making progress					
		I nourishment. Pt is very					
		e " The visit note					
	failed to evidence	ee that the physician and					
		d been notified and					
	patient needs we	ere coordinated with a					
	speech therapist.						
		30/15: " Pt in kitchen					
	l `	g with encouragement.					
		with eating / swallowing					
		and presents better after					
		ort ER [emergency room]					
	visit. Pt still inc	rease weakness and					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 103 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157653	B. W	ING		09/14/	2015
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
					STATE RD 67		
RN2U IN	IC			MOORE	ESVILLE, IN 46158		
(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	<b>+</b>	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		e visit note failed to					
	evidence that the physician and case						
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
	2. The Adminis	trator was interviewed on					
	09/14/15 at 11:4						
		ated she vaguely					
		patient and proceeded to					
	review the patien						
	_	ated she had performed					
	the patient's adm						
	•	as not able to answer nor					
		ech therapy was not					
		patient's case when it was					
		hysician at discharge.					
		for stated the case					
	_	ed in the patient's case					
		agency. During this					
		istrator emailed and					
		acted therapy company					
		es for the coordinator to					
	return her phone	can.					
	2 On 00/14/15	at 1.52 DM tha					
	3. On 09/14/15	·					
		ad a return call from the					
		py company. The					
		ad stated that the					
		n the contracted therapy					
		ted that a speech therapist					
		et with the spouse in July					
	but the services	was declined due to the					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 104 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/14/	ETED			
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158						
(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)	IATE	(X5) COMPLETION DATE		
	did not go out to that assessment Administrator st who the speech to communication is provided by Empaide / office worn Employee N wro of therapy compatherapy], ST had times with no real [doctor] notified interviewed at the did not remember therapist was and the speech therapy physician office day and time the the physician.  4. The complain 09/14/15 at 2:40 stated that the paragivers were the patient would therapy. The constaff would notifically with stated that officially with stated that officially with stated that the official ty with stated that the official type of the off	ated the speech therapist see the patient to make judgment and the ated she did not know therapist was. A note dated 03/26/15, was ployee N, a home health ker, during this time. It is ployee N a home health ker, during this time. It is time and ST. Dr. It is made any ST [speech is called numberous [sic] turn call to ST. Dr. It is made and stated she is time and stated she is time and stated she is time and stated she is the and did not know who poist spoke with at the and did not know what is speech therapist notified that was contacted on PM. The complainant attent and family told upon admission that did be getting speech implainant stated that the sy the office often and face of the patient's							

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 105 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  157653			UILDING	00	COMPL 09/14/	ETED			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158						
(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 APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	complainant state left messages no services had bee complainant indidiscovered this was ame to the home physical therapy the patient had go she was now in a receiving speech.  5. Upon returning 2:55 PM, the Add the speech therapy the said therapy communication is Employee N had the speech therapy through another.  6. An undated prindicated, "Profer promptly alert the changes that sug Plan of Care	eech therapists. The ed no one had called and r was any speech therapy n declined. The icated how he / she was by a therapist that e and was discussing . The complainant stated otten so weak that he / a skilled nursing facility therapy.  In ginside the agency at ministrator stated that pist was not provided by company on the note dated 03/26/15 that I provided / indicated, but pist was provided therapy company.  I provided Plan of Care essional staff shall the physician to any gest a need to alter the							

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 106 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  157653	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF	PROVIDER OR SUPPLIER	635 S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	condition "  484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel. Based on record review and interview, physical and occupational therapy failed to ensure that a patient needs were met by coordinating services with a speech therapist in relation to a patient's difficulty to swallow and weight loss for 1 of 4 records reviewed. (#16)  Findings include:  1. Clinical record number 16, SOC (start of care), for certification period 03/19/15 to 05/17/15 and 05/18/15 to 07/16/15 with orders for skilled nursing, physical and occupational therapy services.  a. A discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a past medical history of aspiration pneumonia and dysphagia. The physician's assessment indicated the pneumonia was resolved		CROSS-REFERENCED TO THE APPROPRIA	10/16/2015  10/16/2015	
	but remains high aspiration risk secondary to dysphagia. Diet at discharge was mechanical soft diet with nectar thickened liquids, and for patient / caregiver to refer to speech therapist with more information on nectar thickened		7. When agency uses a staffing agency to cover a disciplineDON/designee will tract al communications with the staffing agency to ensurethere is timely follow up. (On-going)  8. When a staffing agency is used,	I	

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 107 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUII		NSTRUCTION	(X3) DATE COMPL			
ANDILAN	OF CORRECTION	157653	B. WING		00	09/14/		
		157055				09/14/	2015	
NAME OF F	ROVIDER OR SUPPLIER	L	STREET ADDRESS, CITY, STATE, ZIP CODE					
RN2U IN	С		635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<del></del>	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	Pl	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	liquids. The sun	nmary indicated the			DON/designee will contactstaffing			
	patient was to be	e discharged home with			agency daily, Mon-Fri, for			
	speech therapy.				coordination of care. All contact wil	I		
	-				bedocumented in the appropriate			
	b. A signed	prescription dated			patient's chart. (On-going)  9. If patient/caregiver declines			
	_	ted the patient was to be			therapy services,DON/designee will			
		e with speech therapy			contact patient/family no later than			
	services.				next business day toconfirm they			
					declined therapy. Conversation will			
	c. Occupation	onal therapy notes			be documented in			
	indicated the following	lowing:			appropriatepatient's chart. (On-going)			
	materious ine following.				10. DON/designee will in-service			
	1. 04/08	8/15: " Pt doing fair			professional on requirementto			
	today. Pt c/o [co	omplained of difficulty			contact all disciplines involved in			
		R [Occupational			patient's care and document name	•		
		ered] educated pt			ofperson spoke with along with date and time. (On-going)	е		
	-	-			11. DON/designee will in-service			
		se] / daughter on need for			staff on requirement tonotify MD or	f		
	1 -1	e thickened liquids. Dtr			changes in patient's condition and			
	[daughter] states				document in patient's chart.			
	anything with th	ickener 2* [* secondary]			(On-going) 12. DON/designee will ensure all			
	taste. OTR reco	mmended premixed			disciplines involved inpatient's care			
	thickened liquids	s Teaching / Training:			will participate in case conference.			
	Swallowing tech	nique - chin tuck &			(On-going)			
	ū	needs " The visit note						
		e that the patient needs						
		-						
	were coordinated	d with a speech therapist.						
	2 04/24	5/15: " Pt reported pain						
		ble with swallowing.						
		_						
	_	on drinking thickened						
	liquids after taki	ng bites of crushed up						

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/14/2015				
NAME OF F	PROVIDER OR SUPPLIEF		635 S	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETIC	)N			
		uce or pudding and punts of meds. Pt							
		a pill one day and							
		t up the next day "The to evidence that the							
		ere coordinated with a							
		2/15 note indicated pt was a swallowing. The visit							
		idence that the patient							
	needs were coor therapist.	dinated with a speech							
		2/15 note indicated the ng difficulty swallowing							
	secondary to we	akness. The patient's							
	_	6 on a scale from one to g the worse. The patient							
	also had compla	ined of neck and throat							
	-	lowing difficulties and " The visit note							
		that the patient needs							
	were coordinated	d with a speech therapist.							
	5. 05/19	9/15: " Pain level 4/5							
	at the neck and t	·							
		The visit note failed to e patient needs were							
	ovidence mat the	patient needs were							

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 109 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF I	PROVIDER OR SUPPLIER		•	635 S S	.ddress, city, state, zip code TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	coordinated with	a speech therapist.					
	complain about I importance of nu ensure if pt is un cannot eat regula day" The vis that the patient nutrients Pain" The visit no	1/15: " Pt continues to his throat Discussed attrition and drinking able to swallow and ar diet on any particular it note failed to evidence needs were coordinated erapist.  5/15: " Pt required max llowing food to tuck his as running through entire a coughing and spitting / dd. Pt was very upset and food. Discussed pt later due to lack of to the neck at a level 5 atte failed to evidence that is were coordinated with a					
	speech therapist.						
	pt he / she report all day due to be mod [moderate] [sic] for tucking	6/15: " When talking to ted he / she hadn't eaten ing weak Pt required / max [maximum] v/c his /her chin when table to keep food down					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 110 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV.  A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157653	A. BU B. W		00	09/14/2015	
		137033	Б. W			09/14/2013	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ie	MPLETION DATE
TAG		e visit note failed to		TAG			DATE
	-	e patient needs were					
		•					
	coordinated with a speech therapist.						
	9. 6/11/15: " He reported						
	waking up early and having breakfast but						
	he was unable to	keep it down Pt					
	stated [illegible	writing] for told him /					
	her to drink three ensures a day v/c						
	[sic] required to tuck chin to swallow. Pt						
	required extra tin	me to eat due to problems					
	with swallowing	g " The visit note					
	failed to evidence	ee that the patient needs					
	were coordinate	d with a speech therapist.					
	10. 06/	14/15: " Pt took					
	medication and	v/c [sic] required to tuck					
	chin on swallow	ing " The visit note					
	failed to evidence	ce that the patient needs					
	were coordinate	d with a speech therapist.					
	11. 06/	19/15: " Swallowing					
	difficulty Spe	ech slow, garbled (wet),					
	Pt is continuing	to have weight loss and					
	_	wing. Pt has met max					
	_	e to] these barrier. Pt is					
		and states he gets worn					
		tle he currently does. Pt					
		eficits affecting progress					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  157653			LDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE	
		e visit note failed to						
		e patient needs were						
	coordinated with	a speech therapist.						
	d. Physical the following:	therapy notes indicated						
	1 05/04	5/15: " Pt [patient]						
		coughing and choking on						
	•	The visit note failed to						
		e patient needs were						
	coordinated with	a speech therapist.						
	lost weight and r visit note failed t	7/15: " Pt reports have not eating well " The to evidence that the re coordinated with a						
	3. 05/11	1/15: " Pt having						
	difficulty progre	ssing due to decrease						
	nutrition intake.	" The visit note failed						
		the patient needs were						
	coordinated with	a speech therapist.						
	confusion over p thickener. Pt wa	4/15: " Pt reports breparation of food with as finishing bowl of when PT [physical						
		ц У						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet

Page 112 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. WI	ING		09/14/	/2015
NAME OF 1	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 SVILLE, IN 46158		
(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 DEFICIENCY)	ΤE	COMPLETION
TAG		sent. He / she appeared to		TAG	DEFICIENCY)		DATE
	1 11 1	omited it all back up. Pt					
	having increased difficulty with nutrition						
	1	ote failed to evidence that					
	the patient needs	s were coordinated with a					
	speech therapist.						
	5. 05/2:	5/15: " Pt seated in					
	kitchen and finished with breakfast. Pt is						
	coughing and spitting in trash can "						
		iled to evidence that the					
	1 -	ere coordinated with a					
	speech therapist.	•					
	6. 06/10	6/15: " Pt reports cont					
	difficulty with sv	wallowing and choking.					
	Pt appears to have	ve lost weight and					
	appears malnour	rished Pt's strength					
	decreased slight	ly possibly due to lack of					
	_	ech: See ST [speech					
		owing: See ST " The					
		to evidence that the					
	_	ere coordinated with a					
	speech therapist.						
	7. 06/18	8/15: " Pt drank					
	thickened orange	e juice and had difficulty					
	with aspiration /	coughing " The visit					
	note failed to ev	idence that the patient					

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 113 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ſ ´			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00  B. WING			COMPL	
		157653	B. W	_		09/14/	2015
NAME OF F	PROVIDER OR SUPPLIEF	\ {			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY 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)	ΓE	DATE
	needs were coor	dinated with a speech					
	therapist.	•					
	1						
	8. 06/22	2/15: " Reports not					
	feeling well and	not eating due to					
	choking" Th	e visit note failed to					
	evidence that the	e patient needs were					
	coordinated with	a speech therapist.					
	9. 06/25/15: " Pt reports not						
	feeling well with	n diff [difficulty] to					
	produce words a	s pt is so weak. Pt					
	reports has not e	aten in days Pt's skin					
	color not good, v	very frail and weak. Pt					
	having diff [diff	iuclty] making progress					
	due to decreased	I nourishment. Pt is very					
	weak at this time	e " The visit note					
	failed to evidence	e that the patient needs					
	were coordinated	d with a speech therapist.					
	10. 06/.	30/15: " Pt in kitchen					
	with nurse eating	g with encouragement.					
	Pt still coughing	with eating / swallowing					
	pt doing well	and presents better after					
	IV fluids for sho	ort ER [emergency room]					
		rease weakness and					
	fatigue " The	e visit note failed to					
	-	e patient needs were					
		a speech therapist.					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 114 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		157653	B. W.	ING		09/14/	2015
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
DNOLLIN	•				STATE RD 67		
RN2U IN				MOORE	ESVILLE, IN 46158		
(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 APPROPRIATE OF THE APPROPRIATE	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. The Administrator was interviewed						
	on 09/14/15 at 1	1:45 AM. The					
	Administrator st	ated she vaguely					
	remembered the	patient and proceeded to					
	review the patien	nt's record. The					
	Administrator st	ated she had performed					
	the patient's adm	ission. The					
	Administrator w	as not able to answer nor					
	explain why spec	ech therapy was not					
		patient's case when it was					
	_	hysician at discharge.					
		or stated the case					
		ed in the patient's case					
	-	agency. During this					
		istrator emailed and					
	•	cted therapy company					
		s for the coordinator to					
	return her phone						
	return her phone	can.					
	3. On 09/14/15	at 1:53 PM_the					
		ad a return call from the					
		by company. The					
	Administrator ha						
		the contracted therapy					
		1.5					
		ed that a speech therapist					
		et with the spouse in July					
		was declined due to the					
	patient was "too	•					
		ated the speech therapist					
	_	see the patient to make					
		judgment and the					
		ated she did not know					
	who the speech t	therapist was. A					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 115 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	onstruction 00	COMPL		
		157653	B. W	ING		09/14/	/2015
NAME OF	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	IC				TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LIGHT DEPOT OF THE PROPERTY OF THE PROP		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG	communication is provided by Emplaide / office work Employee N wro of therapy computerapy], ST had times with no religional for the speech therapist was another speech therapist was a state of the speech therapist was another speech therapist was a speech therapist was another speech therapist was another speech therapist was a	called numberous [sic] turn call to ST. Dr.  "Employee N was his time and stated she er who the speech d she did not know who pist spoke with at the and did not know what espeech therapist notified  The complainant attient and family told upon admission that d be getting speech emplainant stated that the fly the office often and fice of the patient's wallowing. The ed that they (patient and es) were not aware that floot getting speech therapy staff portrayed fleech therapists. The ed no one had called and er was any speech therapy		TAG	DEFICIENCY)		DATE

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 116 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/14/2015			
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	discovered this was by a therapist that came to the home and was discussing physical therapy. The complainant stated the patient had gotten so weak that he / she was now in a skilled nursing facility receiving speech therapy.						
	5. Upon returning inside the agency at 2:55 PM, the Administrator stated that the speech therapist was not provided by the said therapy company on the communication note dated 03/26/15 that Employee N had provided / indicated, but the speech therapist was provided through another therapy company.						
	6. An undated policy titled "Coordination of Client Services" indicated, " All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction The physician will be contacted when his / her approval for that change is necessary and to alert physician to changes in client condition "						
G 0195	484.34						

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 117 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 157653		ì í	ILDING	onstruction  00	(X3) DATE COMPI <b>09/14</b> /	ETED
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
PREFIX (EACH DEFICIENT TAG REGULATORY OF	STATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
services, those sigualified social work assis of a qualified social worker assists the members in undersocial and emotion health problems. Based on record to ensure that the notified the physof a patient's different weight loss for (#16)  Findings includ  1. Clinical record for care), for cert to 05/17/15 and 2. The clinical 09/14/15.  a. A social 06/03/15 indica "Possible placer g/tube [gastrostation of consistency foo	dishes medical social ervices are given by a orker or by a qualified tant under the supervision ial worker, and in the plan of care. The social ephysician and other team erstanding the significant onal factors related to the direview, the agency failed are social worker had sician and case manager efficulty to swallow and 1 of 4 records reviewed.	G 01	195	1. Administrator/designee will complete a patient complaintform when receiving a complaint.  (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation andsign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and that all ordered disciplines are scheduled (On-going) 7. When agency uses a staffing agency to cover a disciplineDON/designee will tract all communications with the staffing	e t t.	10/16/2015

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 118 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLET			ΓED
		157653	B. W	ING		09/14/20	015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		635 S STATE RD 67			
RN2U IN	С			MOORESVILLE, IN 46158			
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	she really doesn'	't want g/tube placement			agency to ensurethere is timely		
	Risk factors -	pt [patient] has trouble			follow up. (On-going)		
	swallowing and	then laying down "			8. When a staffing agency is used, DON/designee will contactstaffing		
	The visit note failed to evidence that the				agency daily, Mon-Fri, for		
	physician and ca	se manager had been			coordination of care. All contact wil	l	
					bedocumented in the appropriate		
	notified.				patient's chart. (On-going)		
					9. If patient/caregiver declines		
	b. A social	worker visit note dated			therapy services,DON/designee will		
	06/24/15 indicat	ed the reason for visit:			contact patient/family no later than next business day toconfirm they		
	"Assisting with g/tube placement				declined therapy. Conversation will		
					be documented in		
		patient] is visibly smaller			appropriatepatient's chart.		
	since last visit or	n 6/3. States his / her			(On-going)		
	energy level is p	oor and not eating well at			10. DON/designee will in-service		
	all " The visi	it note failed to evidence			professional on requirementto contact all disciplines involved in		
	that the physicia	n and case manager had			patient's care and document name		
	been notified.				ofperson spoke with along with date	е	
					and time. (On-going)		
	3 An undated n	oolicy titled Plan of Care			11. DON/designee will in-service		
	_	essional staff shall			staff on requirement tonotify MD of		
	· · · · · · · · · · · · · · · · · · ·				changes in patient's condition and document in patient's chart.		
	1	ne physician to any			(On-going)		
		gest a need to alter the			12. DON/designee will ensure all		
	Plan of Care "	•			disciplines involved inpatient's care		
					will participate in case conference.		
		oolicy titled Occupational			(On-going)		
	Therapy indicate	ed, " Communicates					
	plans and change	es to the physician and to					
	nursing Case Ma	anager and other Agency					
	_	e care plan, written					
		and participation in care					
	conferences "						
	conferences						
G 0235	484.48						

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 119 of 241

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) RDS		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	Based on record the agency failed clinical record we contained all accomposition in the relation to speech notes with the age with the patient of compliance were speech of compliance with the cumulative of compliance were speech to the compliance with the patient of compliance were contained to the compliance with the patient of compliance were contained to the compliance with the patient of compliance were contained to the con	review and interview, I to ensure that a patient's	G 0	235	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation andsign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and that all ordered disciplines are scheduled (On-going) 7. When agency uses a staffing agency to cover a disciplineDON/designee will tract all communications with the staffing agency to ensurethere is timely follow up. (On-going) 8. When a staffing agency is used, DON/designee will contactstaffing agency daily, Mon-Fri, for coordination of care. All contact will bedocumented in the appropriate patient's chart. (On-going) 9. If patient/caregiver declines	t d.	10/16/2015

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 120 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  157653	A. BUILDING 00  B. WING		COMPLETED 09/14/2015	
NAME OF P	PROVIDER OR SUPPLIEF		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
(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	
				therapy services,DON/designee will contact patient/family no later than next business day toconfirm they declined therapy. Conversation will be documented in appropriatepatient's chart. (On-going)  10. DON/designee will in-service professional on requirementto contact all disciplines involved in patient's care and document name ofperson spoke with along with date and time. (On-going)  11. DON/designee will in-service staff on requirement tonotify MD of changes in patient's condition and document in patient's chart. (On-going)  12. DON/designee will ensure disciplinesinvolved in patient's care will participate in case conference. (On-going)	all	
G 0236 Bldg. 00	and current finding accepted professi maintained for even health services. It care, the record or identifying informating, dietary, treasigned and dated notes; copies of stattending physicial summary.	ontaining pertinent past gs in accordance with onal standards is ery patient receiving home n addition to the plan of ontains appropriate ation; name of physician; tment, and activity orders; clinical and progress ummary reports sent to the in; and a discharge				
		review and interview, I to ensure that a patient's ras complete and	G 0236	Administrator/designee will complete a patient complaintform when receiving a complaint.  (On-going)	10/16/2015	

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 121 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00	COMPLETED	
		157653	B. W	ING		09/14/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	L			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
						T	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		)N
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
		curate and pertinent			2. All complaint forms will be given		
information in the patient's care in					to Administrator sameday to review		
	relation to speec	h therapy communication			contact person(s) making complaint document conversation	,	
	notes with the ag	gency, physician, and			andsign/date form. (On-going)		
	with the patient	family members.			3. Patient records requested to be		
					mailed will be mailedcertified mail		
	Findings include	:			return receipt requested. (On-going	)	
		-			4. DON/designee will notify		
	1 Clinical reco	d number 16, SOC (start			patient/family same day it		
		·			isdetermined agency cannot provide	e	
		ification period 03/19/15			a discipline. (On-going)		
	to 05/17/15 and	05/18/15 to 07/16/15.			5. DON/designee will notify MD		
					same day it is determinedagency		
	2. The patient's	clinical record was			cannot provide a discipline.		
	reviewed on 09/	14/15. The discharge			(On-going)		
	summary from a	skilled nursing facility			6. DON/designee will review all		
	dated 03/17/15,	indicated the patient had			admissions to ensure agencycan		
		ration pneumonia due to			provide ordered disciplines and that all ordered disciplines are scheduled		
		ad been receiving speech			(On-going)		
	' ' '	is / her inpatient stay.			7. When agency uses a staffing		
	1	ummary had indicated			agency to cover a		
	1	o be discharged home			disciplineDON/designee will tract al		
		· ·			communications with the staffing		
	_	apy services. A signed			agency to ensurethere is timely		
	1 * *	ed 03/17/15 indicated the			follow up. (On-going)		
	l -	we speech therapy at			8. When a staffing agency is used,		
	home.				DON/designee will contactstaffing		
					agency daily, Mon-Fri, for		
	3. A recertificat	ion assessment dated			coordination of care. All contact wil		
	05/15/15, indicated the patient had a				bedocumented in the appropriate patient's chart. (On-going)		
	functional limitation of swallowing,				9. If patient/caregiver declines		
	safety measures / precautions of				therapy services,DON/designee will		
	aspiration and that physical and				contact patient/family no later than		
	occupational therapy was on hold for				next business day toconfirm they		
	_	er speech therapist was			declined therapy. Conversation will		
		• •			be documented in		
	to help with swallowing, increase				annropriatopationt's chart	i	

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  157653	î ´	UILDING	00	COMPL 09/14	ETED	
NAME OF P	PROVIDER OR SUPPLIEF		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	patient to HHC [SN, aide and speinstructed and reways to help deceducated patient thick it [powder fluids to increase in liquids "indicated "Pt applicated "Pt applicated "Pt applicated "Pt applicated with [physical therapy], ST [speins [home health aid who the clinician "Home health aid who the clinician "A. Employee N 109/14/15 at 2:45 indicated she did spoken with and included the dates spoken with the Employee N indication from evaluations wou fax. Employee I communication in up.	in to see pt for swallowing dicated she had in MD [physician], PT y], OT [occupational eech therapy], and HHA del but did not specify ins were.  was interviewed PM. Employee N did not know who she had thought she had es and times that she had speech therapist. icated she would get in therapy by email and lid be sent to the office by N indicated if there was needed, she would type it			(On-going)  10. DON/designee will in-service professional on requirement to contact all disciplines involved in patient's care and document name ofperson spoke with along with da and time. (On-going)  11. DON/designee will in-service staff on requirement tonotify MD of changes in patient's condition and document in patient's chart. (On-going)  12. DON/designee will ensure all disciplines involved inpatient's care will participate in case conference. (On-going)	te of		
		ated she vaguely						

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

Event ID:

78MQ11

Facility ID: 012905

If continuation sheet

Page 123 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ľ	UILDING	onstruction  00	(X3) DATE SURVEY COMPLETED 09/14/2015				
NAME OF	PROVIDER OR SUPPLIEF	<b>X</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	review the patient Administrator state patient's adm Administrator we explain why spe involved in the produced by the produced by the produced by the produced from the time, the Administrator and left message return her phone of the contracted there are administrator has coordinator from company indicate that made contacted the services patient was "too Administrator state and not go out to that assessment administrator state who the speech communication provided by Emaide / office wor administrator was administrator state and provided by Emaide / office wor administrator was administrator state and provided by Emaide / office wor adminis	ated she had performed hission. The as not able to answer nor each therapy was not batient's case when it was hysician at discharge. For stated the case agency. During this istrator emailed and acted therapy company as for the coordinator to a call.  at 1:53 PM, the and a return call from the py company. The and stated that the in the contracted therapy are that a speech therapist at with the spouse in July was declined due to the							

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 124 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA							SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		157653	B. W	ING		09/14/	2015
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DNOLLIN	0				STATE RD 67		
RN2U IN				MOORE	ESVILLE, IN 46158		
(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 APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	of therapy comp						
	1	called numberous [sic]					
		turn call to ST. Dr.					
		." Employee N was					
		is time and stated she					
		er who the speech					
		d she did not know who					
		pist spoke with at the					
	1 * *	and did not know what					
	_	speech therapist notified					
	the physician.						
	1 The complain	ant was contacted on					
	_	PM. The complainant					
	stated that the pa	•					
	_	•					
		told upon admission that					
	_	d be getting speech					
		mplainant stated that the					
		y the office often and					
		ice of the patient's					
	difficulty with sv	· ·					
	_	ed that they (patient and					
	1	s) were not aware that					
		ot getting speech therapy					
	for some of the s	-					
	_	eech therapists. The					
	_	ed no one had called and					
	_	r was any speech therapy					
	services had been declined. The						
		icated how he / she					
	discovered this was by a therapist that						
		e and was discussing					
		. The complainant stated					
	the patient had g	otten so weak that he /					

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

Event ID:

78MQ11 Facility ID: 012905

If continuation sheet Page 125 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		635 S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 RESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	she was now in a receiving speech	skilled nursing facility therapy.			
	2:55 PM, the Ad the speech therap the said therapy communication in Employee N had the speech therap through another to An undated poservices indicate	note dated 03/26/15 that provided / indicated, but bist was provided therapy company.  blicy titled Therapy ed, " Documentation ed within twenty - four			
N 0000 Bldg. 00					
blug. 00	complaint invest		N 0000		
	Survey dates: 09	/14/15			
	Facility number	012905			
	Medicaid Vendo	r#: 201075310			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 126 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	· ·		(X3) DATE	X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157653	B. W	ING		09/14/	2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158			
(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 CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N 0444	Census: 74 Clinical records: 410 IAC 17-12-1(c						
	Home health agen						
Bldg. 00	administration/man Rule 12 Sec. 1(c) a home health age present full time at in order to qualify administrator, who supervising physic required by subsetfollowing:  (1) Organize and agency's ongoing A. Based on receinterview, the Adensure that the paconcern / grievar regards to care the	An individual need not be ency employee or be at the home health agency as its administrator. The enay also be the cian or registered nurse ction (d), shall do the direct the home health functions.	N 0	444	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation		10/16/2015
	Findings included:  1A. Clinical record number 16 SOC				andsign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify	)	
	,	/19/15, included a plan			patient/family same day it		
		ed by the physician for			isdetermined agency cannot provide	9	
		period of 03/19/15 to			a discipline. (On-going)		
	05/17/15 and 05/	/17/15 to 07/16/15.			5. DON/designee will notify MD same day it is determinedagency		
	2A. The Admini	istrator was interviewed			cannot provide a discipline.		
	on 09/14/15 at 2:				(On-going) 6. DON/designee will review all		
		ated she has had no			admissions to ensure agencycan		
I		acea sire mus mud mo	1		1		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 127 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLET		
		157653	B. W	ING		09/14/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			STATE RD 67	
RN2U IN	ıc				ESVILLE, IN 46158	
KINZU IIV				WOOK	=3VILLE, IN 40130	
(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
	complaints and g	grievances since the			provide ordered disciplines and that	:
	previous survey on 08/04/15. The				all ordered disciplines are scheduled	i.
	Administrator st	ated she had only one			(On-going)	
		request medical records			7. When agency uses a staffing	
	_	records was mailed to			agency to cover a	
	the requestor for				disciplineDON/designee will tract all	
	the requestor for	patient #10.			communications with the staffing	
					agency to ensurethere is timely	
	3A. A phone in				follow up. (On-going)	
	complainant on	09/14/15 at 2:40 PM,			8. When a staffing agency is used, DON/designee will contactstaffing	
	stated that he / si	he had been trying to			agency daily, Mon-Fri, for	
	speak with the A	Administrator in regards			coordination of care. All contact will	
	to lack of speech	therapy services and			bedocumented in the appropriate	
	_	n therapy records. The			patient's chart. (On-going)	
		ted he / she kept getting			9. If patient/caregiver declines	
	-				therapy services,DON/designee will	
		ministrator was in a			contact patient/family no later than	
	_	busy. The Administrator			next business day toconfirm they	
		ed his / her phone call.			declined therapy. Conversation will	
	The complainan	t stated he / she had			be documented in	
	never received the	he medical records.			appropriatepatient's chart.	
					(On-going)	
	B. Based on rec	ord review and			10. DON/designee will in-service	
		dministrator failed to			professional on requirementto	
	1	atient / family caregivers			contact all disciplines involved in	
	were informed in				patient's care and document name	
					ofperson spoke with along with date	
	1 2	ed services and the			and time. (On-going)	
		uld be and / or would not			11. DON/designee will in-service staff on requirement tonotify MD of	:
	be provided prio	or to the start of care for 1			changes in patient's condition and	
	of 1 record revie	ewed. (#16)			document in patient's chart.	
					(On-going)	
	Findings include	ed:			12. DON/designee will ensure all	
					disciplines involved inpatient's care	
	1R Clinical rea	ord number 16 SOC			will participate in case conference.	
					(On-going)	
	` ′	3/19/15, included a plan				
	of care establish	ed by the physician for				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 128 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL		NSTRUCTION	(X3) DATE COMPL		
ANDILAN	or correction	157653	B. WING		00	09/14/	
		107000			DDDEGG OFFI CTATE ZID CODE	03/14/	2010
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE TATE RD 67		
RN2U IN	С				SVILLE, IN 46158		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		period of 03/19/15 to					
	05/17/15 and 05/18/15 to 07/16/15, with						
		d nursing, home health					
	aide, physical an	nd occupational therapy.					
	a. A dischar	rge summary from a					
	skilled nursing f	acility dated 03/17/15,					
	indicated the pat	tient had a past medical					
	history of aspira	tion pneumonia and					
	dysphagia. The	physician's assessment					
	indicated the pno	eumonia was resolved					
	but remains high	aspiration risk					
	secondary to dys	sphagia. Diet at					
	discharge was m	nechanical soft diet with					
	nectar thickened	liquids, and for patient /					
	caregiver to refe	er to speech therapist with					
	more informatio	n on nectar thickened					
	liquids. The sun	nmary indicated the					
	patient was to be	e discharged home with					
	speech therapy.	•					
	b. A signed	prescription dated					
	03/17/15, indica	ted the patient was to be					
	discharged home	e with speech therapy					
	services.						
	2D The Admi-	istrator was interviewed					
	on 09/14/15 at 1						
		ated she vaguely					
		patient and proceeded to					
	review the patier						
		ated she had performed					
	the patient's adm						
	Administrator w	as not able to answer nor					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 129 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		î ´	ILDING	nstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/14/2015		
NAME OF	PROVIDER OR SUPPLIEF			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	involved in the prordered by the produced by the process and left message return her phone.  3B. On 09/14/1 Administrator has contracted therapy Administrator has coordinator from company indicate had made contact but the services patient was "too Administrator st did not go out to that assessment Administrator st who the speech communication provided by Employee N wroof therapy comptherapy], ST has times with no re [doctor] notified	5 at 1:53 PM, the ad a return call from the py company. The ad stated that the at the contracted therapy and that a speech therapist at with the spouse in July was declined due to the far gone." The atted the speech therapist asee the patient to make a judgment and the atted she did not know therapist was. A note dated 03/26/15, was ployee N, a home health ker, during this time.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 130 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF	PROVIDER OR SUPPLIER			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
TAG	did not remember therapist was and the speech therapist was and the speech therapist and time the physician office day and time the physician.  4B. The complation of the second of the	cr who the speech d she did not know who pist spoke with at the and did not know what speech therapist notified  inant was contacted on PM. The complainant atient and family told upon admission that d be getting speech implainant stated that the fy the office often and fice of the patient's wallowing. The ed that they (patient and s) were not aware that not getting speech therapy staff portrayed eech therapists. The ed no one had called and r was any speech therapy		TAG	DEFICIENCY)		DATE
	complainant indidiscovered this vacame to the hom physical therapy the patient had g she was now in a receiving speech.  5B. Upon return	icated how he / she vas by a therapist that e and was discussing . The complainant stated otten so weak that he / a skilled nursing facility					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 131 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		r í	UILDING	ONSTRUCTION  00	(X3) DATE COMPI 09/14	LETED	
NAME OF PROVIDER OR S	SUPPLIER			635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	•	
PREFIX (EACH I	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 B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	: IIATE	(X5) COMPLETION DATE
the said the community and the speech through a speech through	nerapy cation is a N had a therapy nother no	pist was not provided by company on the note dated 03/26/15 that I provided / indicated, but pist was provided therapy company.  policy titled Client ess indicated, eria are standards by an be deemed appropriate These standards include as capable of providing the ervice at the level of ent's condition requires I care must conform with onal standards of practice the discipline and should do necessary to the edical disorder admit client or continue tess in the following pe and complexity of met by agency, Skills of agency personnel are meet client needs The essional will verify all the enter the late of the late					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 132 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  157653  A. BUILDING  00  B. WING		COMPLETED 09/14/2015			
NAME OF P	PROVIDER OR SUPPLIER			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	professional If the required heal will be made to t community reson will be notified .						
	and policy review Administrator fa staff efforts were with the physicia	•					
	Findings include  1C. Clinical reco	ord number 16, SOC					
	03/19/15 to 05/1 07/16/15 with or	or certification period 7/15 and 05/18/15 to ders for skilled nursing, upational therapy					
	skilled nursing fa indicated the pat history of aspirat dysphagia. The	-					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 133 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
		157653	B. W.	ING		09/14/	2015
NAME OF F	PROVIDER OR SUPPLIEF	<u>.                                    </u>	_		DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		nechanical soft diet with		TAG			DATE
	_	liquids, and for patient /					
		r to speech therapist with					
		n on nectar thickened					
	_	nmary indicated the edischarged home with					
	speech therapy.	discharged home with					
	24 00000 00000						
	_	prescription dated					
	•	ted the patient was to be					
	discharged home services.	e with speech therapy					
	services.						
	c. Review o	of the skilled nursing					
	notes indicated t	he following:					
		8/15: " SN [skilled					
	""	ed and reviewed with pt					
		chin down when eating					
		t stated had coughing					
	1	ng while eating breakfast.  multivitamin in half and					
	_	while SN watched					
		hin " The visit note					
	_	ee that the physician had					
		d patient needs were					
		a speech therapist.					
		1r					
	2. 04/1	7/15: " Instructed pt on					
	ways to prevent	aspiration and encourage					
	patient to tuck ir	chin when swallowing					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 134 of 241

	OF CORRECTION	IDENTIFICATION NUMBER: 157653	A. BUILDING 00  B. WING			COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	and using thicker	ning with liquids "					
	The visit note fai	iled to evidence that the					
	physician had been notified and patient						
	needs were coordinated with a speech						
	therapist.						
	3. 04/20 on swallowing to fluids " The verified and patience that the notified and patience oordinated with 4. 05/04 thin tuck when dinstructed pt on I thickening of fluid failed to evidence been notified and	20/15: " SN instructed pt echniques, thickening of visit note failed to ephysician had been ent needs were a speech therapist.  4/15: " Instructed pt on rinking and eating SN hydration nutrition and ids " The visit note e that the physician had d patient needs were a speech therapist.					
	on ways to impro chin when taking fluids food " evidence that the notified and patie	7/15: " SN instructed pt ove swallowing tuck in g meds [medications]  The visit note failed to e physician had been ent needs were a speech therapist.					
	coordinated with	га эресси шегарізг.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 135 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	LTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. WIN	NG		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u> </u>	ID	DROWIDERIC DI AN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		5/15: Recertification					
		licated the patient had a					
		tion of swallowing,					
	safety measures	•					
	_	at. Physical and					
	_	rapy was on hold for					
		er the speech therapist					
	Ī	swallowing, increase					
	ĺ	crease strength. The					
	l *	rtified to home health					
		nursing, aide and speech					
	1	illed nurse instructed and					
		atient ways to help					
	1	ion. The skilled nurse					
	1	/ family on dosage of					
		substance to be added to					
		e thickness] to be placed					
	_	tification Summary					
	1	tient's appetite has been					
	1	beech therapy was to see					
	1	vallowing concerns. The					
	skilled nurse ind						
		n physician, physical,					
	_	d speech therapy but did					
	1 * *	the clinicians were. The					
		ailed to evidence patient					
		dinated with a speech					
	therapist.						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 136 of 241

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING 00  B. WING		(X3) DATE SURVEY COMPLETED 09/14/2015				
NAME OF I	PROVIDER OR SUPPLIEF	2	6	STREET A 635 S S MOORE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	7. 06/30	0/15: " SN had pt eat					
	banana, glass of	OJ [orange juice] and ate					
	approx ½ bowl o	of cream of wheat then					
	started to have c	oughing spell, unable to					
	finish all of crea	m of wheat " The visit					
	note failed to ev	idence that the physician					
	had been notified	d and patient needs were					
	coordinated with	a speech therapist.					
	8. Skill	ed nursing discharge					
	summary indicat	ted " Summary of Care					
	Provided to Date	e by Discharging					
	Discipline: SN	for eval [evaluation] and					
	assess [assessme	ent CV [cardiovascular] /					
	Resp [respirator	y] / GI [gastrointestinal] /					
	GU [genitourina	ry] status eval					
	[evaluation] and	assess [assessment]					
	appetite wgt [we	eight] loss (failure to					
	thrive) Patient	t Condition at Discharge:					
	Problems swallo	owing, keeping food,					
	liquids down, ev	en though using					
	thickener. Wgt	loss past 2 weeks, 6					
	pounds Disch	arge Planning /					
	Instructions: Co	ont [continue] to use					
	thickening. Eat	sm [small] freq					
	[frequent] meals	snack thought day.					
	Drink at least 3 -	- 4 Ensure daily with					
	thickener "	The visit note failed to					
	evidence that the	e physician had been					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 137 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  157653		A. B	UILTIPLE CO UILDING /ING	00	COMPI 09/14	LETED	
NAME OF E	PROVIDER OR SUPPLIEI	<b>.</b>		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	_	a speech therapist.					
	d. Occupati indicated the fol	onal therapy notes lowing:					
	today. Pt c/o [cd swallowing. OT Therapist Regist [patient] / [spour pt [patient] to us [daughter] states anything with the taste. OTR reconstitution thickened liquid Swallowing tech [and] thickener processes the swallowing tech case manager has to be swallowed by the swallowing tech patients of the swallowing tech case manager has to be swallowed by the swallowing tech patients of the swallowing tech patients	28/15: " Pt doing fair complained of] difficulty of a complained of] difficulty of a complained of a complained of a complained pt see] / daughter on need for see thickened liquids. Dtr see thickened liquids. Dtr see thickened liquids. Dtr see thickened liquids. Dtr see thickened a complaint of a compl					
	in neck and trou Educated patien liquids after taki meds in applesa	5/15: " Pt reported pain ble with swallowing. t on drinking thickened ng bites of crushed up uce or pudding and ounts of meds. Pt					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 138 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPI		
		157653	B. WI	ING		09/14	/2015
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	a pill one day and tup the next day "The					
		to evidence that the					
		se manager had been					
	notified and pati	-					
	_	a speech therapist.					
	coordinated with	i a specen merapist.					
	3. 04/22	2/15 note indicated pt was					
		swallowing. The visit					
	note failed to evidence that the physician						
		er had been notified and					
	patient needs we	ere coordinated with a					
	speech therapist.						
	4. 05/12	2/15 note indicated the					
	patient was havi	ng difficulty swallowing					
	secondary to we	akness. The patient's					
	•	6 on a scale from one to					
	_	g the worse. The patient					
	_	ined of neck and throat					
	-	lowing difficulties and					
	e e	" The visit note					
		e that the physician and					
	_	d been notified and					
	-	ere coordinated with a					
	speech therapist.						
	5 05/10	9/15: " Pain level 4/5					
	at the neck and t						
	at the neek and t	inoat, decrease					
	l		1				I .

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 139 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO JILDING	00	COMPL		
		157653	B. Wl	ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				STATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION
TAG		The visit note failed to		TAG	Distribute: 1		DATE
		e physician and case					
		en notified and patient					
		dinated with a speech					
	therapist.						
	•						
	6. 05/2	1/15: " Pt continues to					
	complain about	his throat Discussed					
	importance of nu	atrition and drinking					
	ensure if pt is unable to swallow and						
	cannot eat regular diet on any particular						
	day" The vis	it note failed to evidence					
	that the physicia	n and case manager had					
	been notified and	d patient needs were					
	coordinated with	a speech therapist.					
	7 05/2	5/15: " Pt required max					
		llowing food to tuck his					
		as running through entire					
		coughing and spitting /					
		d. Pt was very upset and					
		food. Discussed pt					
	drinking ensure	later due to lack of					
	nutrients Pain	to the neck at a level 5					
	" The visit no	te failed to evidence that					
	the physician an	d case manager had been					
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 140 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		NSTRUCTION 00	(X3) DATE COMPL			
		157653	B. WING			09/14/		
NAME OF I	PROVIDER OR SUPPLIER	}	ST	REET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>		
RN2U IN		-	635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID	1	TATEMENT OF DEFICIENCIES	I III				(V5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)	16	DATE	
		6/15: " When talking to						
	1 ^	ted he / she hadn't eaten						
	-	ing weak Pt required						
	1 -	/ max [maximum] v/c						
		his /her chin when						
		t able to keep food down						
	_	e visit note failed to						
		e physician and case						
	manager had been notified and patient							
	needs were coordinated with a speech							
	therapist.							
	0 6/11	/15: " He reported						
		/15: " He reported and having breakfast but						
	1	keep it down Pt						
		writing] for told him /						
	1	e ensures a day v/c						
		tuck chin to swallow. Pt						
		me to eat due to problems						
	_	: " The visit note						
		te that the physician and						
		d been notified and						
		ere coordinated with a						
	speech therapist.							
	•							
	10. 06/	14/15: " Pt took						
	medication and	v/c [sic] required to tuck						
	chin on swallow	ing " The visit note						
	failed to evidence	ee that the physician and						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 141 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 157653			COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С			S STATE RD 67 DRESVILLE, IN 46158		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	case manager ha	d been notified and				
	patient needs we	re coordinated with a				
	speech therapist.					
	11. 06/1 difficulty Spece Pt is continuing to difficulty swallow potential d/t [due slow to progress out with what litt has nutritional deas well " The evidence that the manager had been needs were coord therapist.  e. Physical to the following:	29/15: " Swallowing ech slow, garbled (wet), so have weight loss and wing. Pt has met max eto] these barrier. Pt is and states he gets worn the he currently does. Pt efficits affecting progress evisit note failed to ephysician and case en notified and patient dinated with a speech etherapy notes indicated				
	•	The visit note failed to				
		physician and case				
		n notified and patient				
	-	dinated with a speech				
	therapist.	_				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 142 of 241

	OF CORRECTION	IDENTIFICATION NUMBER:  157653	A. Bl	A. BUILDING 00  B. WING		COMPLETED 09/14/2015	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE TATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	2. 05/07	7/15: " Pt reports have					
	lost weight and r	not eating well " The					
	visit note failed to evidence that the						
	physician and case manager had been						
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					
	3. 05/11	1/15: " Pt having					
	difficulty progre	ssing due to decrease					
	nutrition intake " The visit note failed						
	to evidence that the physician and case						
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
	4. 05/14	4/15: " Pt reports					
	confusion over p	preparation of food with					
	thickener. Pt wa	s finishing bowl of					
	cream of wheat	when PT [physical					
	therapy] pres	sent. He / she appeared to					
	aspirate it and vo	omited it all back up. Pt					
	having increased	l difficulty with nutrition					
	" The visit no	ote failed to evidence that					
	the physician and	d case manager had been					
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					
	5. 05/25	5/15: " Pt seated in					
		shed with breakfast. Pt is					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 143 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF			635 S S	ADDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
		itting in trash can " iled to evidence that the					
		use manager had been					
	notified and pati	-					
	•	a speech therapist.					
	• • • • • • • • • • • • • • • • • • • •	a w op eeen merup on					
	6. 06/10	6/15: " Pt reports cont					
	difficulty with sv	wallowing and choking.					
	Pt appears to have	ve lost weight and					
	appears malnourished Pt's strength						
	· ·	ly possibly due to lack of					
	-	ech: See ST [speech					
		wing: See ST " The					
	visit note failed	to evidence that the					
		se manager had been					
	notified and pati						
	coordinated with	a speech therapist.					
	7. 06/18	8/15: " Pt drank					
	thickened orange	e juice and had difficulty					
	with aspiration /	coughing " The visit					
	note failed to ev	idence that the physician					
	and case manage	er had been notified and					
	patient needs we	ere coordinated with a					
	speech therapist.						
	8 06/2°	2/15: " Reports not					
		not eating due to					
		e visit note failed to					
	<i>5</i>						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 144 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	evidence that the	e physician and case					
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
	9. 06/25/15: " Pt reports not						
	_	n diff [difficulty] to					
	produce words as pt is so weak. Pt						
	reports has not eaten in days Pt's skin						
	color not good, very frail and weak. Pt						
	having diff [diffiuclty] making progress						
		nourishment. Pt is very					
		e " The visit note					
		te that the physician and					
	_	d been notified and					
	-	ere coordinated with a					
	speech therapist.						
	10 06/3	30/15: " Pt in kitchen					
		g with encouragement.					
		with eating / swallowing					
		and presents better after					
	-	rt ER [emergency room]					
		rease weakness and					
	fatigue " The	e visit note failed to					
	_	e physician and case					
		en notified and patient					
	_	dinated with a speech					
	therapist.	•					
	_						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 145 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015			
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158						
(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)	TE	(X5) COMPLETION DATE		
	on 09/14/15 at 1 Administrator st remembered the review the patient Administrator st the patient's adm Administrator we explain why spe involved in the pordered by the pordered by the pordered by the pordered from the time, the Administrate manager involved retired from the time, the Administrator has contracted the contracted the ray Administrator has coordinator from company indicated that made contact had made contact but the services patient was "too Administrator st did not go out to that assessment Administrator st who the speech to the services of the speech to the speech to the services of the speech to	patient and proceeded to nt's record. The ated she had performed thission. The as not able to answer nor each therapy was not patient's case when it was thysician at discharge. For stated the case agency. During this instrator emailed and ceted therapy company as for the coordinator to eall.  So at 1:53 PM, the and a return call from the pay company. The and stated that the in the contracted therapy are that a speech therapist at with the spouse in July was declined due to the							

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 146 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157653		(X2) MULTIPLE CO A. BUILDING B. WING	<u> </u>		(X3) DATE SURVEY COMPLETED 09/14/2015			
NAME OF I	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	aide / office wor Employee N wro of therapy comp therapy], ST had times with no re [doctor] notified interviewed at the did not remembed therapist was and the speech theraphysician office day and time the the physician.  4C. The complation of the physician office day and time the physician.  4C. The complation of the physician of the physician of the physician.  4C. The complation of the physician of the patient would therapy. The constant would not informed the official difficulty with second aims of the patient was a for some of the second	ted that they (patient and res) were not aware that not getting speech therapy staff portrayed beech therapists. The red no one had called and or was any speech therapy						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 147 of 241

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CO. LDING	NSTRUCTION  00	(X3) DATE COMPL		
		157653	B. WIN	IG		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE	•	
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e and was discussing					
	1	. The complainant stated otten so weak that he /					
		a skilled nursing facility					
	receiving speech therapy.						
	•	ning inside the agency at					
	· ·	ministrator stated that pist was not provided by					
	the said therapy	•					
		note dated 03/26/15 that					
	Employee N had provided / indicated, but						
	the speech therapist was provided						
	through another	therapy company.					
	4E. An undated	policy titled					
	"Coordination of	f Client Services"					
	indicated, "All p	ersonnel furnishing					
	services shall ma	aintain a liaison to assure					
	that their efforts	are coordinated					
	effectively and s	upport the objectives					
	outlined in the P	lan of Care. This may be					
	done through for	rmal care conferences;					
	maintaining com	plete, current Care					
	Plans; and writte	en and verbal interaction					
	The Primary N	Nurse will assume					
	responsibility fo	r updating / changing the					
	Care Plan and co	ommunicating changes to					
	caregivers within	n twenty - four [24] hours					
	following the co	nference or changes.					
	The physician w	ill be contacted when his					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 148 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	changes in client	alert physician to			
	Manager" indica with physicians, professionals [th services], clients	ted, " Collaborates other health care erapists supportive			
	admitting Regist shall discuss the	• •			
N 0484 Bldg. 00	services shall main communications to appropriately com support the object The means of com results shall be do	nce improvement All personnel providing			
	interview, the ag their efforts were	ation, record review and ency failed to ensure e coordinated effectively an and contracted therapy	N 0484	Administrator/designee will complete a patient complaintform when receiving a complaint.  (On-going)	10/16/2015

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 149 of 241

STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157653	B. W	ING		09/14/	2015
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
	<del> </del>			WOOK			
(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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	, ,	e furnishing services for 1			2. All complaint forms will be given		
	of 4 records revi	ewed of patients			to Administrator sameday to review		
	receiving therapy services. (#16)				contact person(s) making complaint	,	
					document conversation		
	Findings include	··			andsign/date form. (On-going)		
					Patient records requested to be mailed will be mailedcertified mail		
	1 Clinical record number 16 SOC (start				return receipt requested. (On-going	, ]	
	1. Clinical record number 16, SOC (start				4. DON/designee will notify	'	
	/ /	ification period 03/19/15			patient/family same day it		
	to 05/17/15 and 05/18/15 to 07/16/15				isdetermined agency cannot provide	2	
	with orders for skilled nursing, physical				a discipline. (On-going)		
	and occupational therapy services.				5. DON/designee will notify MD		
					same day it is determinedagency		
	a. A discharge summary from a				cannot provide a discipline.		
		acility dated 03/17/15,			(On-going)		
		eient had a past medical			6. DON/designee will review all		
	_	•			admissions to ensure agencycan		
		tion pneumonia and			provide ordered disciplines and that	t	
		physician's assessment			all ordered disciplines are scheduled	d.	
	_	eumonia was resolved			(On-going)		
	but remains high	aspiration risk			7. When agency uses a staffing		
	secondary to dys	sphagia. Diet at			agency to cover a		
	discharge was m	echanical soft diet with			disciplineDON/designee will tract al	l	
	_	liquids, and for patient /			communications with the staffing		
		r to speech therapist with			agency to ensurethere is timely		
	~	n on nectar thickened			follow up. (On-going)		
					8. When a staffing agency is used, DON/designee will contactstaffing		
		nmary indicated the			agency daily, Mon-Fri, for		
	_	e discharged home with			coordination of care. All contact wil	1	
	speech therapy.				bedocumented in the appropriate		
					patient's chart. (On-going)		
	b. A signed	prescription dated			9. If patient/caregiver declines		
	03/17/15, indica	ted the patient was to be			therapy services,DON/designee will		
		e with speech therapy			contact patient/family no later than		
	services.	op seen merup;			next business day toconfirm they		
	501 V1003.				declined therapy. Conversation will		
	ъ.	Cd 131 1 :			be documented in		
	c. Review o	c. Review of the skilled nursing			appropriatopationt's chart		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMPLETED 09/14/2015			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	nursing] instruct [patient] tucking and drinking. Pt spell this morning SN had pt break take with ensure patient tuck in clailed to evidence been notified and coordinated with 2. 04/17 ways to prevent patient to tuck in and using thicker. The visit note far physician had be needs were coordinated with 3. 04/20 on swallowing to fluids " The evidence that the notified and patic coordinated with 4. 05/04	8/15: " SN [skilled ed and reviewed with pt chin down when eating stated had coughing g while eating breakfast. multivitamin in half and while SN watched in " The visit note e that the physician had d patient needs were a speech therapist.  7/15: " Instructed pt on aspiration and encourage in chin when swallowing ming with liquids " illed to evidence that the en notified and patient dinated with a speech  9/15: " SN instructed pt echniques, thickening of visit note failed to ephysician had been		(On-going) 10. DON/designee will in-service professional on requirementto contact all disciplines involved in patient's care and document name of personspoke with along with date and time. (On-going) 11. DON/designee will in-service staff on requirement tonotify MD of changes in patient's condition and document in patient's chart. (On-going) 12. DON/designee will ensure all disciplines involved in patient'scare will participate in case conference. (On-going)			
	_	nydration nutrition and ids " The visit note					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 151 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ľ	ILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	been notified and	te that the physician had d patient needs were a speech therapist.						
	on ways to improchin when taking fluids food " evidence that the notified and pati	7/15: " SN instructed pt ove swallowing tuck in g meds [medications] The visit note failed to e physician had been ent needs were n a speech therapist.						
	reassessment incomputational limital safety measures aspiration and the occupational the re-evaluation afted was to help with nutrition, and incompatient was received with skilled therapy. The skilled therapy. The skilled therapy with particular educated patient thick it [powder fluids to increase	rapy was on hold for er the speech therapist swallowing, increase crease strength. The rtified to home health nursing, aide and speech illed nurse instructed and atient ways to help on. The skilled nurse / family on dosage of substance to be added to er thickness] to be placed						
	indicated the pat decreased and sp	tification Summary ient's appetite has been beech therapy was to see vallowing concerns. The icated she had						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 152 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. WI	ING	<u> </u>	09/14	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	(			TATE RD 67		
RN2U IN	С			MOORE	ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		n physician, physical,		1710			DATE
		d speech therapy but did					
	-	the clinicians were. The					
		ailed to evidence patient					
	needs were coor	dinated with a speech					
	therapist.						
		0/15: " SN had pt eat					
	, ,	OJ [orange juice] and ate					
	approx [approximately] ½ bowl of cream						
	of wheat then started to have coughing						
	spell, unable to finish all of cream of						
		visit note failed to					
		e physician had been					
	notified and pati						
	coordinated with	a speech therapist.					
	8. Skill	ed nursing discharge					
		ted " Summary of Care					
		e by Discharging					
	Discipline: SN t	for eval [evaluation] and					
	assess [assessme	ent CV [cardiovascular] /					
	Resp [respirator	y] / GI [gastrointestinal] /					
	GU [genitourina	ry] status eval					
	1 -	assess [assessment]					
	appetite wgt [we						
	· · ·	t Condition at Discharge:					
		wing, keeping food,					
	liquids down, ev						
	1	loss past 2 weeks, 6					
	pounds Disch	-					
		ont [continue] to use					
	thickening. Eat						
	[frequent] meals	snack thought day.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 153 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	(X5) COMPLETION DATE	
	thickener " evidence that the notified and paticoordinated with d. Occupati indicated the following of today. Pt c/o [consumation of the consumation of the cons	onal therapy notes lowing:  8/15: " Pt doing fair omplained of] difficulty [R [Occupational ered] educated pt se] / daughter on need for e thickened liquids. Dtr he won't drink anything * [* secondary] taste. ded premixed thickened ing / Training: nique - chin tuck & needs " The visit note e that the physician and d been notified and re coordinated with a						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 154 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COMPI	(X3) DATE SURVEY COMPLETED 09/14/2015				
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158						
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
	physician and ca notified and pati	to evidence that the se manager had been ent needs were a speech therapist.							
	having difficulty note failed to ev and case manage	2/15 note indicated pt was a swallowing. The visit idence that the physician er had been notified and ere coordinated with a							
	patient was havi secondary to we pain level was a 10 with 10 being also had compla being sore, swall thick congestion failed to evidence case manager ha	2/15 note indicated the ng difficulty swallowing akness. The patient's 6 on a scale from one to g the worst. The patient ined of neck and throat lowing difficulties and" The visit note that the physician and d been notified and the coordinated with a							
	at the neck and t endurance " evidence that the manager had bee needs were coor therapist.	9/15: " Pain level 4/5 hroat, decrease The visit note failed to e physician and case en notified and patient dinated with a speech							

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 155 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015		
NAME O	F PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE	
	importance of mensure if pt is ur cannot eat regulday" The vist that the physicial been notified an coordinated with 7. 05/2 u/c [sic] for swarchin. Pt nose we meal and pt kept throwing up foo wouldn't finish drinking ensure nutrients Pain" The visit not the physician an notified and patic coordinated with 8. 05/2 pt he / she report all day due to be mod [moderate] [sic] for tucking swallowing Pthis day "The evidence that the manager had been seed to see the surface of the	his throat Discussed atrition and drinking hable to swallow and ar diet on any particular bit note failed to evidence in and case manager had dipatient needs were in a speech therapist.  5/15: " Pt required max llowing food to tuck his as running through entire it coughing and spitting / id. Pt was very upset and food. Discussed pt later due to lack of it to the neck at a level 5 bite failed to evidence that id case manager had been ent needs were in a speech therapist.  6/15: " When talking to ited he / she hadn't eaten being weak Pt required / max [maximum] v/c his /her chin when it able to keep food down to evisit note failed to ephysician and case en notified and patient dinated with a speech						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 156 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI		NSTRUCTION 00	(X3) DATE COMPL			
		157653	B. WING	·		09/14/	/2015	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE			
RN2U IN	С		635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1 .	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		EFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG		/15: " He reported		IAG			DAIL	
		and having breakfast but						
	he was unable to	keep it down Pt						
		writing] for told him /						
		e ensures a day v/c						
		tuck chin to swallow. Pt						
	_	me to eat due to problems						
	_	that the physician and						
	failed to evidence that the physician and case manager had been notified and							
patient needs were coordinated with a								
	speech therapist.							
	specen incrapist.							
	10. 06/	14/15: " Pt took						
	medication and	v/c [sic] required to tuck						
	chin on swallow	ing " The visit note						
		e that the physician and						
	_	d been notified and						
	_	ere coordinated with a						
	speech therapist.							
	11. 06/	19/15: " Swallowing						
		ech slow, garbled (wet),						
		to have weight loss and						
	difficulty swallo	wing. Pt has met max						
	potential d/t [due	e to] these barrier. Pt is						
	slow to progress	and states he gets worn						
		tle he currently does. Pt						
		eficits affecting progress						
		e visit note failed to						
		e physician and case						
	_	en notified and patient						
		dinated with a speech						
	therapist.							

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 157 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	<u>00</u>	COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RN2U IN	С			STATE RD 67 ESVILLE, IN 46158	
(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
TAG	e. Physical the following:  1. 05/05 reports increase of food / meds " evidence that the manager had been needs were coord therapist.  2. 05/07 lost weight and revisit note failed to physician and can notified and patic coordinated with  3. 05/11 difficulty progremutrition intake at the evidence that manager had been needs were coordinated with the series were coordinated.  4. 05/14 confusion over progrems.	therapy notes indicated  5/15: " Pt [patient] coughing and choking on The visit note failed to e physician and case en notified and patient dinated with a speech  7/15: " Pt reports have not eating well " The to evidence that the se manager had been	TAG	DEFICIENCY)	DATE
	cream of wheat wherapy] pressure it and vo	when PT [physical sent. He / she appeared to omited it all back up. Pt I difficulty with nutrition			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 158 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/14/2015				
NAME OF F	PROVIDER OR SUPPLIEF		635 S	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE		
	megulatory or the physician an notified and paticoordinated with 5. 05/22 kitchen and finise coughing and sp. The visit note far physician and can notified and paticoordinated with 6. 06/16 [continued] difficult and choking. Pt weight and appesstrength decrease to lack of nutritic [speech therapy] " The visit note of the physician and can be considered with the coordinated with t	ote failed to evidence that d case manager had been ent needs were a speech therapist.  5/15: " Pt seated in whed with breakfast. Pt is itting in trash can " illed to evidence that the use manager had been ent needs were a speech therapist.  6/15: " Pt reports cont culty with swallowing appears to have lost ars malnourished Pt's ed slightly possibly due on Speech: See ST ; Swallowing: See ST ote failed to evidence that		CROSS-REFERENCED TO THE APPROP	RIATE			
	the physician an notified and paticoordinated with 7. 06/13 thickened orange with aspiration / note failed to evand case manage	d case manager had been ent needs were a a speech therapist.  8/15: " Pt drank e juice and had difficulty coughing" The visit idence that the physician er had been notified and ere coordinated with a						
	8. 06/22	2/15: " Reports not						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 159 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ILTIPLE CO ILDING	NSTRUCTION  00	(X3) DATE COMPL			
		157653	B. WI	NG		09/14/	/2015	
NAME OF F	PROVIDER OR SUPPLIEF		•	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)		TE	(X5) COMPLETION DATE	
	choking" The evidence that the manager had been	not eating due to e visit note failed to e physician and case en notified and patient dinated with a speech						
	feeling well with produce words a reports has not e color not good, v having diff [diffi due to decreased weak at this time failed to evidence case manager ha	5/15: " Pt reports not a diff [difficulty] to s pt is so weak. Pt aten in days Pt's skin very frail and weak. Pt iculty] making progress I nourishment. Pt is very e " The visit note that the physician and d been notified and the coordinated with a						
	with nurse eating Pt still coughing pt doing well IV fluids for sho visit. Pt still inc fatigue " The evidence that the manager had bee	30/15: " Pt in kitchen g with encouragement. with eating / swallowing and presents better after art ER [emergency room] rease weakness and e visit note failed to e physician and case en notified and patient dinated with a speech						
	f. Social wo	ork visit notes indicated						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 160 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		î ´	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(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)	TE	(X5) COMPLETION DATE	
	1. 06/03	3/15: Reason for visit:						
	"Possible placen	nent: Assisted Living,						
	g/tube [gastrosto	omy tube] His / her						
	biggest concern	is having to eat nectar						
	consistency food	ls / drinks 2* [*						
	secondary] swall	lowing difficulties. He /						
	she really doesn'	t want g/tube placement						
	Risk factors - pt [patient] has trouble							
	swallowing and then laying down "							
	The visit note failed to evidence that the							
	physician had been notified.							
	2. 06/24	4/15: Reason for visit:						
	"Assisting with	g/tube placement						
	concerns Pt is	visibly smaller since last						
	visit on 6/3. Sta	tes his energy level is						
	poor and not eat	ing well at all " The						
	visit note failed	to evidence that the						
	physician had be	een notified.						
	2. The Adminis	trator was interviewed on						
	09/14/15 at 11:4	5 AM. The						
		ated she vaguely						
		patient and proceeded to						
	review the patien							
	the patient's adm	ated she had performed						
	•	as not able to answer nor						
		ech therapy was not						
		patient's case when it was						
		hysician at discharge.						
		or stated the case						
	manager involve	ed in the patient's case						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 161 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTI A. BUILDI B. WING		NSTRUCTION  00	(X3) DATE : COMPL 09/14/	ETED			
NAME OF F	PROVIDER OR SUPPLIEF		63	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	III PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	time, the Admin called the contra	agency. During this istrator emailed and cted therapy company s for the coordinator to call.							
	contracted therapy Administrator has coordinator from	nd a return call from the py company. The ad stated that the n the contracted therapy							
	company indicated that a speech therapist had made contact with the spouse in July but the services was declined due to the patient was "too far gone." The Administrator stated the speech therapist								
	that assessment Administrator st who the speech t	/ judgment and the ated she did not know therapist was. A							
	provided by Empaide / office wor	note dated 03/26/15, was ployee N, a home health ker, during this time. ote "According to [Name anyl ST [speech							
	therapy], ST had times with no re [doctor] notified	l called numberous [sic] turn call to ST. Dr. ." Employee N was his time and stated she							
	did not remembe therapist was and the speech therap physician office	er who the speech d she did not know who pist spoke with at the and did not know what e speech therapist notified							

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 162 of 241

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   157653   B. WING
NAME OF PROVIDER OR SUPPLIER  RN2U INC  STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  the physician.  4. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
RN2U INC  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  THE physician.  4. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and  635 S STATE RD 67  MOORESVILLE, IN 46158  ID  PROVIDERS PLANOF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  OMPLETION  TAG  1D  PROVIDERS PLANOF CORRECTION  (CX5)  COMPLETION  DATE  COMPLETION  DATE
RN2U INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (A. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and (X5)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1 D PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1 A THE COMPLETION DATE  1 D PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1 A THE COMPLETION DATE  2 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  2 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  2 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  2 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  2 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  3 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  3 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  3 A THE CACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE  4 A THE CACH CORRECTIVE ACTION DATE  4 A THE CACH CO
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  COMPLETION DATE  COMPLETION DATE  COMPLETION DATE  COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  A. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
the physician.  4. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
4. The complainant was contacted on 09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
09/14/15 at 2:40 PM. The complainant stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
stated that the patient and family caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
caregivers were told upon admission that the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
the patient would be getting speech therapy. The complainant stated that the staff would notify the office often and
therapy. The complainant stated that the staff would notify the office often and
staff would notify the office often and
difficulty with swallowing. The
complainant stated that they (patient and
family caregivers) were not aware that
the patient was not getting speech therapy
for some of the staff portrayed
themselves as speech therapists. The
complainant stated no one had called and
left messages nor was any speech therapy
services had been declined. The
complainant indicated how he / she
discovered this was by a therapist that
came to the home and was discussing
physical therapy. The complainant stated
the patient had gotten so weak that he /
she was now in a skilled nursing facility
receiving speech therapy.
5. Upon returning inside the agency at
2:55 PM, the Administrator stated that
the speech therapist was not provided by
the said therapy company on the
communication note dated 03/26/15 that
Employee N had provided / indicated, but
the speech therapist was provided

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 163 of 241

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE STATE RD 67	
RN2U IN	С			ESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	6. An undated p "Coordination of indicated, "All p services shall may that their efforts effectively and s outlined in the P done through for maintaining com Plans; and writte The Primary N responsibility for Care Plan and cocaregivers within following the corresponsibility for Care Plan and cocaregivers within following the corresponsibility for Care Plan and cocaregivers within following the corresponsibility for Care Plan and cocaregivers within following the corresponsibility for Care Plan and cocaregivers within following the corresponsibility for Care physician with physician with physicians, professionals [th services], clients developing a correlation of care "  8. An undated p of Client Services assessment, the assessment, the assessment is serviced assessment.	ersonnel furnishing sintain a liaison to assure are coordinated support the objectives lan of Care. This may be smal care conferences; plete, current Care n and verbal interaction surse will assume supdating / changing the summunicating changes to n twenty - four [24] hours inference or changes. sill be contacted when his rethat change is alert physician to condition.  olicy titled "RN Case ted," Collaborates other health care erapists supportive			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 164 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	<u> </u>		COMPLETED 09/14/2015				
NAME OF I	PROVIDER OR SUPPLIEF	<u>I</u>	635 S S	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
	Clinical manage personnel furnishmaintain a liaiso efforts are coord support the object Plan of Care. The formal care confiction complete, current and verbal interaction with the conference of will be contacted for that change in physician to characteristic for the conference of th	who is the case manager.  Il participate in e physician's plan of care lient progress "  policy titled herapy indicated, " blans and changes to the nursing Case Manager y Staff through the care							

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 165 of 241

, , ,		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> B. WING			COMPLETED	
		157653	B. W	ING		09/14/	2015	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
RN2U IN	С			635 S STATE RD 67 MOORESVILLE, IN 46158				
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
N 0504	410 IAC 17-12-3(b	o)(2)(D)(i)						
N 0504  Bldg. 00	Patient Rights Rule 12 (b) The p exercise his or her home health agen (2) The patient h following: (D) Be informed a furnished, and of a be furnished, and of a be furnished as fol (i) The home hea the patient in adva (AA) disciplines th (BB) frequency o furnished. Based on record the agency failed patient / family o in advance of the services and the or would not be p speech therapy p for 1 of 1 record  Findings include  1. Clinical record of care) 03/19/15 established by th certification perio 05/17/15 and 05/ orders for skilled	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 llows: hat hagency shall advise ance of the: hat will furnish care; and f visits proposed to be review and interview, I to ensure that the caregivers were informed be physician ordered services that would and / provided in relation to rior to the start of care reviewed. (#16)	N 0	504	1. Administrator/designee wil complete a patient complaints when receiving a complaint. (On-going) 2. All complaint for will be given to Administrator sameday to review, contact person(s) making complaint, document conversation and sign/date form. (On-going) Patient records requested to mailed will be mailedcertified return receipt requested. (On-going) 4. DON/designee winotify patient/family same day isdetermined agency cannot provide a discipline. (On-going DON/designee will notify MD same day it is determinedager cannot provide a discipline. (On-going) 6. DON/designee wreview all admissions to ensur agencycan provide ordered disciplines and that all ordered	orm ms 3. pe mail it g) 5. ncy will re	10/16/2015	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 166 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		 UILDING	00	COMPL 09/14/	ETED		
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(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)	ATE	(X5) COMPLETION DATE	
	skilled nursing findicated the pathistory of aspirar dysphagia. The indicated the pathistory of aspirar dysphagia. The indicated the pathistory of aspirar dysphagia. The indicated the pathistory of aspirar dysphagia. The surface caregiver to reference information liquids. The surface patient was to be speech therapy.  b. A signed 03/17/15, indicated discharged homoservices.  2. The Administrator stremembered the review the patient Administrator stremembered the review the patient's administrator we explain why specially involved in the produced by the patient Administrator we are administrator when the patient and	sphagia. Diet at sechanical soft diet with liquids, and for patient / r to speech therapist with n on nectar thickened mary indicated the edischarged home with prescription dated ted the patient was to be with speech therapy trator was interviewed on 5 AM. The ated she vaguely patient and proceeded to nt's record. The ated she had performed		(On-going) 7. When agency to a staffing agency to cover a disciplineDON/designee will to all communications with the staffing agency to ensurether timely follow up. (On-going) 8 When a staffing agency is use DON/designee will contactstate agency daily, Mon-Fri, for coordination of care. All contacts will bedocumented in the appropriate patient's chart. (On-going) 9. If patient/careging declines therapy services, DON/designee will contact patient/family no later than next business day tocommunicate the patient of the declined therapy. Conversation will be document in appropriate patient's chart. (On-going) 10. DON/designee in-service professional on requirement contact all disciplines involved in patient's care and document name of person spoke with along with date and time. (On-going) 11. DON/designee will in-service on requirement tonotify MD of changes in patient's condition document in patient's chart. (On-going) 12. DON/designee ensure all disciplines involved inpatient's care will participate case conference. (On-going)	ract e is . ed, fffing act ver firm ated e will s th staff f and e will		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 167 of 241

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	
		157653	B. W	ING		09/14/2015	
NAME OF I	DROWIDED OF CUIDNIES		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			635 S S	STATE RD 67		
RN2U IN	С			MOORE	ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BELIEEE, C. T.		DATE
		agency. During this					
		istrator emailed and					
		icted therapy company					
	and left messages for the coordinator to						
	return her phone call.						
	3. On 09/14/15	at 1:53 PM, the					
		ad a return call from the					
	contracted thera	py company. The					
	Administrator ha	ad stated that the					
	coordinator fron	the contracted therapy					
	company indicated that a speech therapist						
	had made contact with the spouse in July						
		was declined due to the					
	patient was "too	far gone." The					
	-	ated the speech therapist					
		see the patient to make					
	_	/ judgment and the					
		ated she did not know					
	who the speech	therapist was. A					
	-	note dated 03/26/15, was					
		ployee N, a home health					
	1 *	ker, during this time.					
		ote "According to [Name					
	of therapy comp	<b>G</b> 2					
		l called numberous [sic]					
		turn call to ST. Dr.					
	[doctor] notified	l." Employee N was					
		nis time and stated she					
		er who the speech					
		d she did not know who					
	_	pist spoke with at the					
		and did not know what					
		e speech therapist notified					
	1		1				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 168 of 241

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUII		NSTRUCTION 00	(X3) DATE COMPL	
111,12 12,111	or condition.	157653	B. WIN		00	09/14/	
		******	<del></del>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			TATE RD 67		
RN2U IN	С				SVILLE, IN 46158		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	the physician.						
	1 The complain	nant was contacted on					
		PM. The complainant					
		atient and family					
		told upon admission that					
		d be getting speech					
therapy. The complainant stated that the							
staff would notify the office often and							
informed the office of the patient's							
difficulty with swallowing. The							
	complainant stated that they (patient and						
	_	rs) were not aware that					
	1 -	not getting speech therapy					
	for some of the s						
		beech therapists. The					
		ed no one had called and					
		r was any speech therapy					
	services had bee						
	complainant ind	icated how he / she					
	discovered this v	was by a therapist that					
	came to the hom	e and was discussing					
	physical therapy	. The complainant stated					
	the patient had g	otten so weak that he /					
	she was now in a	a skilled nursing facility					
	receiving speech	therapy.					
	5 Upon returni	ng inside the agency at					
	_	Iministrator stated that					
	· · · · · · · · · · · · · · · · · · ·	pist was not provided by					
	the said therapy						
		note dated 03/26/15 that					
		I provided / indicated, but					
		pist was provided					
	i *	•	1				I

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 169 of 241

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	î ´	ILDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/14</b> /	ETED
NAME OF P	ROVIDER OR SUPPLIEF			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 SVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	through another	therapy company.					
	6. An undated particle Admission Proces "Admission crites which a client care for admission." In the Agency is needed care or so intensity the client profession of the respective be reasonable and treatment of a magency will not to provide service situations Sconeeds cannot be and suitability of not adequate to a admission profession of the provide services, treatment of a magency will not admission profession of a client / caregiver services, treatment of a client / caregiver possible Upon admission of a cregistered Nurse the individual to professional If the required head will be made to service the client of the required head will be made to service the client of the required head will be made to service the client of the required head will be made to service the client of the required head will be made to service the client of the required head will be made to service the client of the required head will be made to service the client of the required head will be made to service the required head will be serviced t	colicy titled Client cess indicated, cria are standards by an be deemed appropriate These standards include as capable of providing the cervice at the level of cent's condition requires It care must conform with conal standards of practice the discipline and should and necessary to the cedical disorder admit client or continue cess in the following the peand complexity of met by agency, Skills for agency personnel are meet client needs The cessional will verify all the the Intake Form with the the Intake Form with the the rand obtain input when the acceptance and lient, the admitting the appropriately skilled the agency cannot fulfill the care need, a referral the other appropriate					
	community reso	urces and referral source	- 1				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 170 of 241

STATEMENT OF AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/14/2015	
NAME OF PROVI	IDER OR SUPPLIER			635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
	(EACH DEFICIENC	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)	ΓE	(X5) COMPLETION DATE
Bldg. 00  Ru (b) or l agg (3) rep law unl hea pat ann clir Ba the rec rec  Fin  1. of est cei 05  2. 09 sta rec rec	ther rights as a pency as follows: The patient or oresentative has a to access the pless certain except the procedures reduced to a gency failed cords were proquest. (#16) Indings include Clinical record care) 03/19/15 Itablished by the crification period to the Administ period to the Administration period to	as the right to exercise his patient of the home health repatient's legal at the right under Indiana patient's clinical records eptions apply. The home II advise the patient or the esentative of its policies garding the accessibility of review and interview, I to ensure that medical vided upon a caregiver's	N 0.	510	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation and sign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going) 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan	)	10/16/2015

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 171 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE ( A. BUILDING B. WING	00	COMPLETED 09/14/2015	
NAME OF I	PROVIDER OR SUPPLIER		635 S	FADDRESS, CITY, STATE, ZIP CODE STATE RD 67 RESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5)  DBE COMPLETION  DATE
	stated that he / s speak with the A to lack of speech requested speech complainant stat told that the Adr meeting or was had never return The complainan never received to	he had been trying to administrator in regards in therapy services and in therapy records. The red he / she kept getting ministrator was in a busy. The Administrator ed his / her phone call. It stated he / she had he medical records.		provide ordered disciplines and all ordered disciplines are sched (On-going)  7. When agency uses a staffing agency to cover a disciplineDON/designee will tracommunications with the staffin agency to ensurethere is timely follow up. (On-going)  8. When a staffing agency is use DON/designee will contactstaffing agency daily, Mon-Fri, for coordination of care. All contact bedocumented in the appropriate patient's chart. (On-going)  9. If patient/caregiver declines therapy services, DON/designee contact patient/family no later to next business day toconfirm the declined therapy. Conversation be documented in appropriate patient's chart. (On-going)  10. DON/designee will in-service professional on requirement to contact all disciplines involved in patient's care and document na of person spoke with along with and time. (On-going)  11. DON/designee will in-service staff on requirement tonotify Mochanges in patient's condition a document in patient's chart. (On-going)  12. DON/designee will ensure a disciplines involved inpatient's cwill participate in case conferent (On-going)	duled.  ct all ng d, ng e will the will than ey will e n me date e ID of nd
N 0514	410 IAC 17-12-3(	c)			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 172 of 241

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653			JILDING	00	COMPL 09/14/	ETED
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				STATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	TE	(X5) COMPLETION DATE
Bidg. 00	following: (1) Investigate or patient or the patier representative reg following: (A) Treatment or furnished. (B) The lack of reproperty by anyon behalf of the home (2) Document be complaint and the complaint.  Based on record the agency failed patient / family or grievance was in care that was not for 1 of 4 record  Findings include  1. Clinical record for are) 03/19/15 established by the certification periods/17/15 and 05/17/15 and 05/17/15 at 2:15 stated she has has grievances since 08/04/15. The A	oth the existence of the resolution of the review and interview, I to ensure that the earegivers concern / evestigated in regards to a furnished by the agency reviewed. (#16)	NO	514	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation andsign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and that all ordered disciplines are scheduled (On-going)	e t	10/16/2015

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 173 of 241

	OF CORRECTION	IDENTIFICATION NUMBER: 157653	A. BUILDING B. WING	00	COMPLETED 09/14/2015
NAME OF P	PROVIDER OR SUPPLIEF		635 S	ADDRESS, CITY, STATE, ZIP C STATE RD 67 RESVILLE, IN 46158	ODE
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION PPROPRIATE DATE
	were mailed to the #16.  3. A phone intercomplainant on the stated that he / stated that he / stated that he / stated that he A to lack of speech requested speech complainant stated that the Admeeting or was that had never return. The complainant stated that the Admeeting or was the had never return.	and the medical records the requestor for patient  rview with the 199/14/15 at 2:40 PM, the had been trying to administrator in regards therapy services and therapy records. The ted he / she kept getting the had been trying to administrator was in a therapy records. The ted he / she had the phone call. the stated he / she had the medical records.		7. When agency uses a stafagency to cover a disciplineDON/designee wit communications with the sagency to ensurethere is tiffollow up. (On-going) 8. When a staffing agency in DON/designee will contact agency daily, Mon-Fri, for coordination of care. All condition of care. All conditions are contact agency daily, Mon-Fri, for coordination of care. All conditions are contact agency daily, Mon-Fri, for coordination of care. All conditions agency daily, Mon-Fri, for coordination of care. All conditions agency daily, Mon-Fri, for coordination of care. All conditions agency daily, Mon-Fri, for coordination of care. All conditions agency daily, Mon-Fri, for coordination of care. All conditions agency daily, Mon-Fri, for coordination of care. All conditions agency designer declined in appropriate patient's chart. (On-going) 10. DON/designee will in-sonated all disciplines involved in patient's chart. (On-going) 11. DON/designee will in-sonated in patient's chart. (On-going) 12. DON/designee will ensured in case conficients agency ag	Il tract all taffing mely sused, staffing mely sused, staffing mtact will opriate mes gnee will ater than m they stion will ervice mtto wed in mt name with date ervice ify MD of ion and t.
N 0520	410 IAC 17-13-1(a Patient Care				
Bldg. 00	Rule 13 Sec. 1(a) accepted for care				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 174 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  09/14/2015	
NAME OF I	PROVIDER OR SUPPLIEF	<b>1</b>	•	635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	ATE	(X5) COMPLETION DATE
	reasonable expect health needs can home health agenresidence.  Based on record the agency failed patient's needs we speech therapy so for care for 1 of 1.  Findings includes 1. Clinical record of care) 03/19/11 established by the certification periods/17/15 and 05 orders for skilled aide, physical and a. A dischart skilled nursing findicated the pathistory of aspirar dysphagia. The	tation that the patient's be adequately met by the acy in the patient's place of review and interview, do to ensure that the acre met in relation to services, prior to the start a record reviewed. (#16)  add:  and number 16 SOC (start 5, included a plan of care the physician for the acid of 03/19/15 to 07/16/15, with do nursing, home health and occupational therapy.  arge summary from a facility dated 03/17/15, then thad a past medical tion pneumonia and physician's assessment elemonia was resolved in aspiration risk	NO		1. Administrator/designee will complete a patient complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact person(s) making complaint document conversation and sign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going) 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and the all ordered disciplines are schedule (On-going) 7. When agency uses a staffing agency to cover a	v, t, g) le	
	discharge was m nectar thickened caregiver to refe more informatio liquids. The sun	r to speech therapist with n on nectar thickened nmary indicated the			disciplineDON/designee will tract a communications with the staffing agency to ensurethere is timely follow up. (On-going) 8. When a staffing agency is used, DON/designee will contactstaffing agency daily, Mon-Fri, for		
	speech therapy.	e discharged home with			coordination of care. All contact wi bedocumented in the appropriate	II	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 175 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	construction 00	(X3) DATE SURVEY  COMPLETED	
		157653	B. WING	<u>00                                   </u>	09/14/2015
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE STATE RD 67	30,11,2010
RN2U IN	С		MOOF	RESVILLE, IN 46158	
(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
	b. A signed 03/17/15, indicar discharged home services.  2. The Administrator stremembered the review the patient Administrator st the patient's adm Administrator we explain why speinvolved in the pordered by the pordered by the pordered by the pordered from the time, the Administrator was retired from the time, the Administrator was retired from the time, the Administrator has contracted therapy Administrator has coordinator from company indicated had made contacted that the contracted therapy and the contracted therapy Administrator has coordinator from company indicated had made contacted therapy and the contracted therapy and the contracted therapy and the coordinator from company indicated the contracted the coordinator from company indicated the coordinator from company indicated the contracted the coordinator from company indicated the coordinator from company indicated the contracted the coordinator from company indicated the coordinator from coordinator f	prescription dated ted the patient was to be the with speech therapy  trator was interviewed on 5 AM. The ated she vaguely patient and proceeded to nt's record. The ated she had performed dission. The as not able to answer nor each therapy was not reatient's case when it was hysician at discharge. For stated the case and in the patient's case agency. During this distrator emailed and ceted therapy company s for the coordinator to call.  at 1:53 PM, the and a return call from the dry company. The and stated that the and the contracted therapy ed that a speech therapist at with the spouse in July was declined due to the		patient's chart. (On-going)  9. If patient/caregiver declines therapy services, DON/designee w contact patient/family no later the next business day toconfirm they declined therapy. Conversation w be documented in appropriatepatient's chart. (On-going)  10. DON/designee will in-service professional on requirementto contact all disciplines involved in patient's care and document nam ofperson spoke with along with diand time. (On-going)  11. DON/designee will in-service staff on requirement tonotify MD changes in patient's condition and document in patient's chart. (On-going)  12. DON/designee will ensure all disciplines involved inpatient's car will participate in case conference (On-going)	ill an ill e e ate of
	patient was 100	iai gone. The			

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING		COMPI	COMPLETED 09/14/2015	
	PROVIDER OR SUPPLIER		635	EET ADDRESS, CITY, STATE, ZIP CODE S STATE RD 67		
RN2U IN	С		MOC	ORESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	E RIATE	(X5) COMPLETION DATE
	did not go out to that assessment / Administrator star who the speech to communication approvided by Emplaide / office work Employee N wro of therapy compatherapy], ST had times with no reteled interviewed at the did not remember therapist was and the speech therapy physician office day and time the the physician.  4. The complaint 09/14/15 at 2:40 stated that the paragivers were the patient would therapy. The constaff would notificately with sweethers of the official ty with sweethers of the patient would the official ty with sweethers of the patient would notificately with sweethers.	note dated 03/26/15, was ployee N, a home health ker, during this time. It "According to [Name any] ST [speech a called numberous [sic] turn call to ST. Dr.  "Employee N was as it time and stated she for who the speech dishe did not know who pist spoke with at the and did not know what speech therapist notified want was contacted on PM. The complainant attent and family told upon admission that dibe getting speech mplainant stated that the fixth of the patient's wallowing. The led that they (patient and so) were not aware that not getting speech therapy				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 177 of 241

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

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BU	A. BUILDING 00  B. WING		COMPLETED 09/14/2015			
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
RN2U IN	С			635 S STATE RD 67 MOORESVILLE, IN 46158				
(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)	λΤЕ	(X5) COMPLETION DATE	
TAG	themselves as sp complainant state left messages not services had been complainant indidiscovered this we came to the home physical therapy the patient had go she was now in a receiving speech.  5. An undated poly Admission Procests and the services and current can be intensity the clien. The services and current profession for the respective be reasonable and treatment of a mean and the services are services and the services and the services are services and the services are services as the s	eech therapists. The ed no one had called and r was any speech therapy n declined. The cated how he / she was by a therapist that e and was discussing . The complainant stated otten so weak that he / n skilled nursing facility therapy.		TAG	DEFICIENCY)		DATE	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 178 of 241

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157653	B. W	ING		09/14/	2015
NAME OF D	DOWNER OF CURRINE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	•		635 S S	STATE RD 67		
RN2U IN					ESVILLE, IN 46158		
(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
1716		ent, and care with the		1710			DATE
	client / caregiver	and obtain input when					
	possible Upon	acceptance and					
	admission of a c	lient, the admitting					
	Registered Nurse	e / Therapist will assign					
		the appropriately skilled					
	professional It	f the agency cannot fulfill					
	the required health care need, a referral						
	will be made to the other appropriate						
		urces and referral source					
	will be notified.	"					
N 0527	410 IAC 17-13-1(a	a)(2)					
	Patient Care						
Bldg. 00	Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency						
		t the person responsible					
	for the medical co	mponent of the patient's					
		es that suggest a need to					
	alter the medical p		N 0	527	1. Administrator/designee will		10/16/2015
		review and interview,  I to ensure that the	1110	<i>341</i>	complete a patient complaintfo	orm	10/10/2013
		comptly notified of the			when receiving a complaint.		
	1 2	herapy services at the			(On-going)2. All complaint form	ns	
	•	notified of the patient's			will be given to Administrator sameday to review, contact		
		wallowing and weight			person(s) making complaint,		
	loss for 1 of 4 re				document conversation		
	1555 151 1 51 1 10	-0.1.00 101101104.			andsign/date form. (On-going) Patient records requested to b		
	Findings include	<i>:</i>			mailed will be mailedcertified r		
	_				return receipt requested.		
	1. Clinical recor	d number 16, SOC (start			(On-going)4. DON/designee w		
		ification period 03/19/15			notify patient/family same day it isdetermined agency cannot		
	to 05/17/15 and	05/18/15 to 07/16/15			provide a discipline. (On-going	g)5.	
	with orders for s	killed nursing, physical			DON/designee will notify MD		
	and occupational	l therapy services.			same day it is determinedager cannot provide a discipline.	тсу	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 179 of 241

NAME OF PROVIDER OR SUPPLIER  RNZU INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCES (35 S STATE RO 67 MOORE SVILLE, IN 46158  (X5) ID SUMMARY STATEMENT OF DEFICIENCES (35 S STATE RO 67 MOORE SVILLE, IN 46158  (X6) ID SUMMARY STATEMENT OF DEFICIENCES (35 S STATE RO 67 MOORE SVILLE, IN 46158  (X6) ID SUMMARY STATEMENT OF DEFICIENCES (35 S STATE RO 67 MOORE SVILLE, IN 46158  (X6) ID SUMMARY STATEMENT OF DEFICIENCES (35 S STATE RO 67 MOORE SVILLE, IN 46158  (X6) ID SUMMARY STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID SUMMARY STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X7) ID SUMMARY STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID SUMMARY STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID STATEMENT OF SAME STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X7) ID STATEMENT OF THE STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID STATEMENT OF SAME STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X7) ID STATEMENT OF SAME STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID STATEMENT OF SAME STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID STATEMENT OF SAME STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID STATEMENT OF SAME STATEMENT OF DEFICIENCES (37 MOORE SVILLE, IN 46158  (X6) ID STATEMENT OF SAME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLEE  RN2U INC  OX9 ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a history of aspiration pneumonia due to dysphagia and had been receiving speech therapy during his / her inpatient stay.  This discharge summary had indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  STRIPT ADDRIES, CITY, STATE, JPP COBIL (33 S STATE RD 67 MOORESVILLE, IN 46158  MOORESVILLE, IN 46158  D. MOORESVILLE, IN 46158  (On-going)B. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and that all ordered disciplines are scheduled. (On-going)B. DON/designee will tract all communications with the staffing agency to ensurethere is timely follow up. (On-going)B. When a staffing agency to ensure there is timely follow up. (On-going)B. When Private a disciplines upon the staffing agency to ensure there is timely follow up. (On-going)B. When Private all disciplines in stendy to the patient's chart. (On-going)B. Mon-Pri, for coordination of care. All contact staffing agency to ensure there is timely follow up. (On-going)B. To provide staffing agency to ensure there is timely follow up. (On-going)B. To provide staffing agency to ensure there is timely follow up. (On-going)B. To provide a discipli	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
RNZU INC  RNZU INC  SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while cating break fast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin "The visit note failed to evidence that the physician had been notified.  SIMMARY STATE RD 67 MOORESVILLE, IN 46158  D. CXS1 COMPLETION			157653	B. WI	NG		09/14/	2015
RNZU INC  RNZU INC  SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while cating break fast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin "The visit note failed to evidence that the physician had been notified.  SIMMARY STATE RD 67 MOORESVILLE, IN 46158  D. CXS1 COMPLETION					STREET A	ADDRESS, CITY, STATE, ZIP CODE		
INCLUDION SUMMARY STATEMENT OF DEFICIENCES TAG  RECHARCH ONLY IS EXPECTEDED BY FULL TAG  a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient stay. This discharge summary haid indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin" The visit note failed to evidence that the physician had been notified.  MOORESVILLE, IN 46158  ID RECORDERT AN OF CORNECTION OF COMPLETION COMPLETION PREFIX TAG  RECULATORY OR ISCLIDATIFYING INFORMATION)  TAG  (On-going)12. DON/designee will ordered disciplines are scheduled. (On-going)12. DON/designee will ordered disciplines and that ordered disciplines and the ordered disciplines and the ordered disciplines and the all ordered disciplines and tordered disciplines and tordered disciplines and the all ordered disciplines and the all ordered disciplines are scheduled. (On-going)7. When agency uses a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to cover a disciplines are scheduled. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to cover a disci	NAME OF F	PROVIDER OR SUPPLIER						
REFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a history of aspiration pneumonia due to dysphagia and had been neceiving speech therapy during his / her inpatient stay. This discharge summary had indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  PREFIX TAG  (On-going)6. DON/designee will review all admissions to ensure agency acceptant produced disciplines and that all ordered disciplines and that all ordered disciplines are scheduled. (On-going)7. When agency to cover a disciplines and that all ordered disciplines are scheduled. (On-going)8. When a staffing agency to cover a discipline and that all ordered the patient s	RN2U IN	С						
TAG  REGULATORY OR I SC IDENTIFYING INFORMATION)  a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a history of aspiration pneumonia due to dysphagia and had been receiving speech therapy during his / her inpatient stay. This discharge summary had indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  PREPEX TAG  (On-going)6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and that all ordered disciplines and that all ordered disciplines are scheduled. (On-going)7. When agency uses a staffing agency to cover a disciplines and that all ordered disciplines and that all ordered disciplines are scheduled. (On-going)8. When a staffing agency to cover a disciplines are scheduled. (On-going)8. When a staffing agency to seave a staffing agency to cover a disciplines and that all ordered disciplines are disciplines and that all ordered disciplines are disciplines are all disciplines are all connacted and incomminations of the staffing agency to cover a disciplines are all disciplines are scheduled. (On-going)8. When a staffing agency to cover a disciplines are all di	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a history of aspiration pneumonia due to dysphagia and had been receiving speech therapy during his / her inpatient stay. This discharge summary had indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  TAG  (On-going)6. DON/designee will and minishins on ensure agency on provide disciplines and that all ordered disciplines and respect use of disciplines and respect use at affing agency to cover a disciplines and respect use of siciplines and respect use	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
a. The patient's clinical record was reviewed on 09/14/15. The discharge summary from a skilled nursing facility dated 03/17/15, indicated the patient had a history of aspiration pneumonia due to dysphagia and had been receiving speech therapy during his / her inpatient stay. This discharge summary had indicated the patient was to be discharged home with speech therapy services. A signed prescription dated 03/17/15 indicated the patient was to have speech therapy at home. The agency failed to notify the physician of the inability to provide speech therapy services.  b. Review of the skilled nursing notes indicated the following:  1. 04/08/15: " SN [skilled nursing] instructed and reviewed with pt [patient] tucking chin down when eating and drinking. Pt stated had coughing spell this morning while eating breakfast. SN had pt break multivitamin in half and take with ensure while SN watched patient tuck in chin " The visit note failed to evidence that the physician had been notified.  "review all admissions to ensure agencycan provide ordered disciplines are scheduled. (On-going)12 at staffing agency to cover a disciplines are scheduled. (On-going)18. When a staffing agency to cover a disciplines gagency to cover a disciplines pew ill contacts affing agency to ensure there is timely follow up. (On-going)8. When a staffing agency to ensure there is timely follow up. (On-going)8. When a staffing agency to ensure there is timely follow up. (On-going)8. When a staffing agency to cover a disciplines atfiling agency to cover a disciplines atfiling agency to cover a disciplines (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)8. When a staffing agency to ensurethere is timely follow up. (On-going)9. When a staffing agency to ensurethere is timely follow up. (On-going)9. When a staffing agency to ensurethere is timely follow up. (On-going)9. When a staffing agency to ensurethere is timely follow up. (On-going)	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
2. 0 // // 10 Indudered pt	IAG	a. The patier reviewed on 09/2 summary from a dated 03/17/15, is a history of aspir dysphagia and hat therapy during hat therapy during hat This discharge so the patient was to with speech therapy summary from the patient was to hat home. The agent physician of the speech therapy summary summary from the speech therapy summary from the speech thera	nt's clinical record was 14/15. The discharge skilled nursing facility indicated the patient had ration pneumonia due to ad been receiving speech is / her inpatient stay. Immary had indicated to be discharged home apy services. A signed indicated the receives are speech therapy at cy failed to notify the inability to provide ervices.  If the skilled nursing the following:  18/15: " SN [skilled the ed and reviewed with pt chin down when eating the stated had coughing the stated had coughing the stated with the entire that the physician had the skilled nursing the following the eating breakfast.  18/15: " SN [skilled the physician had the physici		IAU	(On-going)6. DON/designee w review all admissions to ensuragencycan provide ordered disciplines and that all ordered disciplines are scheduled. (On-going)7. When agency use a staffing agency to cover a disciplineDON/designee will trall communications with the staffing agency to ensurethere timely follow up. (On-going)8. When a staffing agency is used DON/designee will contactstaff agency daily, Mon-Fri, for coordination of care. All contact will bedocumented in the appropriate patient's chart. (On-going)9. If patient/caregived declines therapy services, DON/designee will contact patient/family no later than next business day toconfit they declined therapy. Conversation will be document in appropriate patient's chart. (On-going)10. DON/designee win-service professional on requirementto contact all disciplines involved in patient's care and document name ofperson spoke with along with date and time. (On-going)11. DON/designee will in-service son requirement tonotify MD of changes in patient's condition adocument in patient's chart. (On-going)12. DON/designee wensure all disciplines involved inpatient's care will participate ensure all disciplines involved inpatient's care will participate	es es es ect is d, fing ct er rm ted will s and	DATE

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 180 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  B. WING			A. BUILDING		COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE S STATE RD 67		
RN2U IN	С			RESVILLE, IN 46158		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	on ways to preve	ent aspiration and				
	encourage patien	t to tuck in chin when				
	swallowing and	using thickening with				
	liquids " The	e visit note failed to				
	evidence that the	physician had been				
	notified.					
	2 04/26	)/45 W GN :				
3. 04/20/15: " SN instructed						
pt on swallowing techniques, thickening						
of fluids " The visit note failed to						
evidence that the physician had been						
	notified.					
	4 05/04	1/15: " Instructed pt				
		n drinking and eating				
		on hydration nutrition				
	-	f fluids " The visit				
	C	dence that the physician				
	had been notified	* *				
	naa ooon nonnee	4.				
	5. 06/30	0/15: " SN had pt eat				
	banana, glass of	OJ [orange juice] and ate				
	approx ½ bowl o	of cream of wheat then				
	started to have co	oughing spell, unable to				
	finish all of crear	m of wheat " The				
	visit note failed t	to evidence that the				
	physician had be	en notified.				
	6. Skille	ed nursing discharge				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 181 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		r í	JILDING	onstruction  00	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	summary indicat	ted " Summary of					
	Care Provided to	Date by Discharging					
	Discipline: SN	for eval and assess CV					
	[cardiovascular]	/ Resp [respiratory] / GI					
	[gastrointestinal]	] / GU [geniturinary]					
	status eval [eval	uation] and assess					
	[assessment] app	petite wgt [weight] loss					
	(failure to thrive	e) Patient Condition at					
Discharge: Problems swallowing,							
keeping food, liquids down, even							
ghough using thickener. Wgt loss past 2							
	weeks, 6 pounds	s Discharge Planning /					
	Instructions: Co	ont to use thickening. Eat					
	sm [small] freq [	[frequent]meals snack					
	thought day. Dr	rink at least 3 - 4 Ensure					
	daily with thicke	ener " The visit note					
	failed to evidence	ce that the physician had					
	been notified.						
	c. Occupati	onal therapy notes					
	indicated the fol	lowing:					
	1. 04/08	8/15: " Pt doing fair					
	today. Pt c/o [co	omplained of] difficulty					
	swallowing. OT	R [Occupational					
	Therapist Regist	tered] educated pt					
	[patient] / [spous	se] / daughter on need for					
	pt [patient] to us	se thickened liquids. Dtr					
	[daughter] states	s he won't drink anything					
	with thickener 2	* [* secondary] taste.					
	OTR recommend	ded premixed thickened					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 182 of 241

AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157653		ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF F	ROVIDER OR SUPPLIER	<b>.</b>		635 S S	NDDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
	liquids Teachi	ing / Training:					
	Swallowing tech	nnique - chin tuck &					
		needs " The visit note					
		e that the physician had					
	been notified.						
	2. 04/2:	5/15: " Pt reported					
	pain in neck and	trouble with					
	swallowing. Ed	ucated patient on					
drinking thickened liquids after taking							
bites of crushed up meds in applesauce or							
pudding and taking small amounts of							
	meds. Pt reporte	ed taking a pill one day					
	and coughing it	back up the next day "					
	The visit note fa	iled to evidence that the					
	physician had be	een notified.					
		2/15 note indicated pt was					
		swallowing. The visit					
		idence that the physician					
	had been notified	d.					
		2/15 note indicated the					
	*	ng difficulty swallowing					
	secondary to we	akness. The patient's					
	•	6 on a scale from one to					
	10 with 10 being	g the worst. The patient					
	also had compla	ined of neck and throat					
	being sore, swall	lowing difficulties and					
	thick congestion	" The visit note					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 183 of 241

	OF CORRECTION	IDENTIFICATION NUMBER: 157653	A. Bl	A. BUILDING 00  B. WING		COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	failed to evidence been notified.	e that the physician had					
	at the neck and the endurance "	9/15: " Pain level 4/5 hroat, decrease The visit note failed to physician had been					
	complain about I importance of nu ensure if pt is un cannot eat regula day " The vis	1/15: " Pt continues to nis throat Discussed attrition and drinking able to swallow and ar diet on any particular sit note failed to evidence in had been notified.					
	max u/c [sic] for his chin. Pt nose entire meal and p spitting / throwin upset and would! Discussed pt drin lack of nutrients level 5 " The	swallowing food to tuck was running through of kept coughing and ag up food. Pt was very n't finish food.  hking ensure later due to Pain to the neck at a e visit note failed to e physician had been					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 184 of 241

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED
NAME OF F	PROVIDER OR SUPPLIEF	<b>.</b>	635 S S	NDDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
		6/15: " When talking				
to pt he / she reported he / she hadn't						
eaten all day due to being weak Pt						
	required mod [m	-				
		[sic] for tucking his / her				
		owing Pt able to keep				
	food down this d	lay " The visit note				
		ee that the physician had				
	been notified.					
	waking up early he was unable to stated [illegible of to drink three en required to tuck required extra tin with swallowing	and having breakfast but be keep it down Pt writing for told him / her sures a day v/c [sic] chin to swallow. Pt me to eat due to problems g The visit note failed the physician had been				
	medication and chin on swallow	14/15: " Pt took  v/c [sic] required to tuck  ing " The visit note  the that the physician had				
		19/15: " Swallowing ech slow, garbled (wet),				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 185 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653  A. BUILDING  00  B. WING			COMPLETED 09/14/2015		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE STATE RD 67	
RN2U IN	С			ESVILLE, IN 46158	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Pt is continuing t	to have weight loss and			
	difficulty swallor	wing. Pt has met max			
	potential d/t [due	e to] these barrier. Pt is			
	slow to progress	and states he gets worn			
	out with what litt	tle he currently does. Pt			
	has nutritional de	eficits affecting progress			
	as well " The	visit note failed to			
	evidence that the	physician had been			
notified.					
	d. Physical the following:	therapy notes indicated			
	reports increase of food / meds '	5/15: " Pt [patient] coughing and choking on The visit note failed to physician had been			
	lost weight and revisit note fair physician had be  3. 05/11 difficulty progresultrition intal failed to evidence	7/15: " Pt reports have not eating well " The led to evidence that the en notified.  7/15: " Pt having ssing due to decrease ke " The visit note e that the physician had			
	been notified.				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 186 of 241

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  4. 05/14/15: " Pt reports confusion over preparation of food with thickener. Pt was finishing bowl of cream of wheat when PT [physical	i i	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING  B. WING			
RN2U INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  4. 05/14/15: " Pt reports confusion over preparation of food with thickener. Pt was finishing bowl of cream of wheat when PT [physical]  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETIC DATE  (A) 05/14/15: " Pt reports confusion over preparation of food with thickener. Pt was finishing bowl of cream of wheat when PT [physical]				PROVIDER OR SUPPLIER	NAME OF P
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  4. 05/14/15: " Pt reports confusion over preparation of food with thickener. Pt was finishing bowl of cream of wheat when PT [physical				С	RN2U IN
confusion over preparation of food with thickener. Pt was finishing bowl of cream of wheat when PT [physical	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLETION	PREFIX	CY MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX
aspirate it and vomited it all back up. Pt having increased difficulty with nutrition " The visit note failed to evidence that the physician had been notified.  5. 05/25/15: " Pt seated in kitchen and finished with breakfast. Pt is coughing and spitting in trash can " The visit note failed to evidence that the physician had been notified.  6. 06/16/15: " Pt reports cont [continued] difficulty with swallowing and choking. Pt appears to have lost weight and appears malnourished Pt's strength decreased slightly possibly due to lack of nutrition Speech: See ST [speech therapy]; Swallowing: See ST " The visit note failed to evidence that the physician had been notified.  7. 06/18/15: " Pt drank thickened orange juice and had difficulty			reparation of food with a finishing bowl of when PT [physical ent. He / she appeared to mited it all back up. Pt difficulty with nutrition at failed to evidence that I been notified.  /15: " Pt seated in med with breakfast. Pt is tting in trash can"  led to evidence that the en notified.  /15: " Pt reports cont culty with swallowing appears to have lost ars malnourished Pt's ad slightly possibly due on Speech: See ST Swallowing: See ST Swallowing: See ST te failed to evidence that d been notified.	confusion over prothickener. Pt was cream of wheat we therapy] press aspirate it and voo having increased " The visit not the physician had so the physician had been so the physician had been strength decreased to lack of nutritic [speech therapy]; " The visit not the physician had so the physician had the physic	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 187 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	G 00		E SURVEY PLETED	
		157653	B. WING		09/1	4/2015
NAME OF I	PROVIDER OR SUPPLIEF	<b>.</b>		ET ADDRESS, CITY, STATE, ZIP	CODE	
RN2U IN	С			S STATE RD 67 DRESVILLE, IN 46158		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION )	RRECTION	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE
	with aspiration /	coughing " The visit				
	note failed to ev	idence that the physician				
	had been notified	d.				
	8 06/2	2/15: " Reports not				
		not eating due to				
		ne visit note failed to				
		e physician had been				
	notified.					
	9. 06/2:	5/15: " Pt reports not				
	feeling well with	n diff to produce words as				
	pt is so weak. P	t reports has not eaten in				
	days Pt's skin	color not good, very frail				
	and weak. Pt ha	ving diff [diffiuclty]				
	making progress	due to decreased				
	nourishment. Pt	is very weak at this time				
	" The visit no	ote failed to evidence that				
	the physician ha	d been notified.				
	10. 06/3	30/15: " Pt in kitchen				
		g with encouragement.				
	Pt still coughing	with eating / swallowing				
	pt doing well	and presents better after				
	IV fluids for sho	ort ER [emergency room]				
	visit. Pt still inc	rease weakness and				
	fatigue " The	e visit note failed to				
	evidence that the	e physician had been				
	notified.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 188 of 241

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G  00	COM	TE SURVEY MPLETED 14/2015	
NAME OF P	ROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO I	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	e. Social wo	ork visit notes indicated					
	"Possible placen g/tube [gastrosto biggest concern consistency food secondary] swall she really doesn' Risk factors - swallowing and	lowing difficulties. He / 't want g/tube placement pt [patient] has trouble then laying down " iled to evidence that the					
	"Assisting with a concerns Pt is visit on 6/3. Sta poor and not eat visit note failed physician had be 2. The Administrator st remembered the	trator was interviewed on 5 AM. The ated she vaguely patient and proceeded to					
	review the patient Administrator st	nt's record. The ated she had performed					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 189 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPLETED 09/14/2015	
		157653	B. W			09/14/	/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				TATE RD 67 ESVILLE, IN 46158		
							T
(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)	TE	DATE
	the patient's adm	· · · · · · · · · · · · · · · · · · ·					
		as not able to answer nor					
		ech therapy was not					
		patient's case when it was					
	_	hysician at discharge.					
		or stated the case					
		ed in the patient's case					
	_	agency. During this					
		istrator emailed and					
	called the contra	cted therapy company					
	and left message	es for the coordinator to					
	return her phone	call.					
	3. On 09/14/15	at 1:53 PM, the					
	Administrator ha	ad a return call from the					
	contracted therap	py company. The					
	Administrator ha	ad stated that the					
	coordinator from	the contracted therapy					
	company indicat	ed that a speech therapist					
	had made contac	et with the spouse in July					
	but the services	was declined due to the					
	patient was "too	far gone." The					
		ated the speech therapist					
		see the patient to make					
		judgment and the					
		ated she did not know					
	who the speech t	-					
		note dated 03/26/15, was					
	1	ployee N, a home health					
		ker, during this time.					
		ote "According to [Name					
	of therapy compa						
		called numberous [sic]					
	times with no ret	turn call to ST. Dr.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 190 of 241

	OF CORRECTION	IDENTIFICATION NUMBER: 157653	A. BUILDING B. WING	00	COMPLETED 09/14/2015
NAME OF I	PROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRI DEFICIENCY)	
	interviewed at the did not remembe therapist was and the speech therapphysician office	" Employee N was is time and stated she er who the speech d she did not know who bist spoke with at the and did not know what speech therapist notified			
	indicated, "Profe promptly alert th	olicy titled Plan of Care essional staff shall e physician to any gest a need to alter the			
	Therapy indicate plans and change nursing Case Ma Staff through the	olicy titled Occupational ed, " Communicates es to the physician and to anager and other Agency care plan, written nd participation in care			
N 0545 Bldg. 00	services are limite purposes of practi	(1)(F) Except where d to therapy only, for ce in the home health ered nurse shall do the			
	interview, the Re ensure their effor documented effe	ation, record review, and egistered Nurse failed to rts were coordinated and ctively with the ntracted therapy agency	N 0545	Administrator/designee will complete a patient complaintform when receiving a complaint.      (On-going)     All complaint forms will be given to Administrator sameday to revie	1

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 191 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPLETED
		157653	B. W	ING		09/14/2015
				STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹				
DNOLLIN	0				STATE RD 67	
RN2U IN	C			WOOR	ESVILLE, IN 46158	
(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
	that were furnishing services for 1 of 4				contact person(s) making complaint	.,
records reviewed of patients receiving				document conversation		
services. (#16)				andsign/date form. (On-going)		
	Scrvices. (#10)				3. Patient records requested to be	
					mailed will be mailedcertified mail	
	Findings include	2.			return receipt requested. (On-going	)
					4. DON/designee will notify	
	1. Clinical reco	rd number 16, SOC (start			patient/family same day it	
		ification period 03/19/15			isdetermined agency cannot provide	e
	, ,	05/18/15 to 07/16/15			a discipline. (On-going)	
					5. DON/designee will notify MD	
with orders for skilled nursing, physical				same day it is determinedagency		
and occupational therapy services.				cannot provide a discipline.		
					(On-going)	
	a. A discharge summary from a				6. DON/designee will review all	
	skilled nursing f	acility dated 03/17/15,			admissions to ensure agencycan	
		tient had a past medical			provide ordered disciplines and that	t
	_	•			all ordered disciplines are scheduled	d.
	1 -	tion pneumonia and			(On-going)	
		physician's assessment			7. When agency uses a staffing	
	indicated the pno	eumonia was resolved			agency to cover a	
	but remains high	n aspiration risk			disciplineDON/designee will tract al	I
	secondary to dys	sphagia. Diet at			communications with the staffing	
	1	nechanical soft diet with			agency to ensurethere is timely	
	1	liquids, and for patient /			follow up. (On-going)	
		-			8. When a staffing agency is used,	
		r to speech therapist with			DON/designee will contactstaffing	
		n on nectar thickened			agency daily, Mon-Fri, for	
	liquids. The sun	nmary indicated the			coordination of care. All contact wil	l
	patient was to be	e discharged home with			bedocumented in the appropriate	
	speech therapy.				patient's chart. (On-going)	
					9. If patient/caregiver declines	
	h A signad	prescription detad			therapy services,DON/designee will	
	_	prescription dated			contact patient/family no later than	
	· · · · · · · · · · · · · · · · · · ·	ted the patient was to be			next business day toconfirm they	
	discharged home	e with speech therapy			declined therapy. Conversation will	
	services.				be documented in	
					appropriatepatient's chart.	
	c Review c	of the skilled nursing			(On-going)	
	I C. ICCVICW C	or are skilled hursing	ı		10. DON/designee will in-service	1

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 192 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157653		ľ í	JILDING	instruction 00	(X3) DATE : COMPL 09/14/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF			635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158		
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	notes indicated to  1. 04/03 nursing] instruct [patient] tucking and drinking. Prespell this morning SN had pt break take with ensure patient tuck in clear failed to evidence been notified and coordinated with  2. 04/17 ways to prevent patient to tuck in and using thicke The visit note fa physician had be needs were coor therapist.  3. 04/20 on swallowing to fluids " The evidence that the notified and patient	he following:  8/15: " SN [skilled ed and reviewed with pt chin down when eating stated had coughing ag while eating breakfast.  multivitamin in half and while SN watched hin " The visit note see that the physician had do patient needs were a speech therapist.  7/15: " Instructed pt on aspiration and encourage a chin when swallowing ming with liquids " illed to evidence that the seen notified and patient dinated with a speech  2/15: " SN instructed pt echniques, thickening of visit note failed to exphysician had been			professional on requirementto contact all disciplines involved in patient's care and document name ofperson spoke with along with data and time. (On-going)  11. DON/designee will in-service staff on requirement tonotify MD of changes in patient's condition and document in patient's chart. (On-going)  12. DON/designee will ensure all disciplines involved inpatient's care will participate in case conference. (On-going)		
	4. 05/04 thin tuck when coinstructed pt on	4/15: " Instructed pt on Irinking and eating SN hydration nutrition and ids " The visit note					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 193 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ľ	ILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF I	PROVIDER OR SUPPLIER			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	been notified and	te that the physician had d patient needs were a speech therapist.					
	on ways to improchin when taking fluids food " evidence that the notified and pati	7/15: " SN instructed pt ove swallowing tuck in g meds [medications] The visit note failed to e physician had been ent needs were n a speech therapist.					
	reassessment inci- functional limital safety measures aspiration and the occupational the re-evaluation aft was to help with nutrition, and inci- patient was received with skilled therapy. The skilled therapy. The skilled therapy with particular aspiration of the skilled therapy with skil	rapy was on hold for er the speech therapist swallowing, increase crease strength. The rtified to home health nursing, aide and speech illed nurse instructed and atient ways to help on. The skilled nurse / family on dosage of substance to be added to er thickness] to be placed					
	indicated the pat decreased and sp	tification Summary ient's appetite has been beech therapy was to see vallowing concerns. The icated she had					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 194 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G 00	СОМ	e survey pleted 4/2015	
NAME OF I	PROVIDER OR SUPPLIER		635	EET ADDRESS, CITY, STA 5 S STATE RD 67 OORESVILLE, IN 4615		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	occupational, an not specify who clinical record faneeds were coord therapist.	n physician, physical, d speech therapy but did the clinicians were. The niled to evidence patient dinated with a speech				
	banana, glass of approx [approxion of wheat then state spell, unable to find wheat " The weighted and pating the state of the state	O/15: " SN had pt eat OJ [orange juice] and ate mately] ½ bowl of cream arted to have coughing finish all of cream of visit note failed to e physician had been ent needs were a a speech therapist.				
	summary indicate Provided to Date Discipline: SN to assess [assessme Resp [respiratory GU [genitourina [evaluation] and appetite wgt [westhrive) Patient Problems swallo liquids down, even thickener. Wgt pounds Dischall Instructions: Conthickening. Eat	for eval [evaluation] and ent CV [cardiovascular] / y] / GI [gastrointestinal] / ry] status eval assess [assessment] eight] loss (failure to a Condition at Discharge: wing, keeping food, een though using loss past 2 weeks, 6 large Planning / ent [continue] to use				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 195 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:		JLTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. WI		<u>oo                                   </u>	09/14/		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	2			TATE RD 67			
RN2U IN	С			MOORE	ESVILLE, IN 46158			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		- 4 Ensure daily with		TAG	DLI ICILI (CT)		DATE	
		The visit note failed to						
	evidence that the physician had been notified and patient needs were							
	coordinated with a speech therapist.							
		- w -p						
	2. The Adminis	trator was interviewed on						
	09/14/15 at 11:45 AM. The							
	Administrator stated she vaguely							
	remembered the patient and proceeded to							
	review the patient's record. The							
	Administrator stated she had performed							
	the patient's adm							
		as not able to answer nor						
		ech therapy was not						
	_	patient's case when it was						
		hysician at discharge.						
		or stated the case						
	_	ed in the patient's case						
		agency. During this						
	i i	istrator emailed and						
		cted therapy company						
	_	es for the coordinator to						
	return her phone	can.						
	3. On 09/14/15	at 1:53 PM_the						
		ad a return call from the						
		by company. The						
	Administrator ha							
		the contracted therapy						
		ed that a speech therapist						
		et with the spouse in July						
		was declined due to the						
	patient was "too	far gone." The						
	1		ı				1	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 196 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMPLETED 09/14/2015	
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE STATE RD 67	
RN2U IN	С			ESVILLE, IN 46158	
(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
	Administrator sta	ated the speech therapist			
		see the patient to make			
		judgment and the ated she did not know			
	who the speech t	note dated 03/26/15, was			
		ployee N, a home health			
		ker, during this time.			
		ote "According to [Name			
	of therapy compa				
	1 2 1	called numberous [sic]			
		turn call to ST. Dr.			
	[doctor] notified	." Employee N was			
	interviewed at th	is time and stated she			
	did not remembe	er who the speech			
	therapist was and	d she did not know who			
		pist spoke with at the			
		and did not know what			
	-	speech therapist notified			
	the physician.				
	4. The complain	ant was contacted on			
		PM. The complainant			
	stated that the pa	-			
		told upon admission that			
	_	d be getting speech			
		mplainant stated that the			
	· '	y the office often and			
		ice of the patient's			
	difficulty with sv	<del>-</del>			
	_	ed that they (patient and			
		s) were not aware that			
	•	ot getting speech therapy			
	for some of the s	tan pomayeu			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 197 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMPLETED 09/14/2015	
NAME OF P	PROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	complainant state left messages not services had been complainant indi discovered this we came to the home physical therapy, the patient had g she was now in a receiving speech  5. Upon returnit 2:55 PM, the Ad the speech therapy the said therapy communication in Employee N had the speech therapy through another in 6. An undated p "Coordination of indicated, "All per services shall may that their efforts effectively and so outlined in the Pi done through for maintaining com Plans; and writte The Primary N responsibility for	cated how he / she was by a therapist that e and was discussing. The complainant stated of the so weak that he / a skilled nursing facility therapy.  In ginside the agency at ministrator stated that pist was not provided by company on the note dated 03/26/15 that provided / indicated, but pist was provided therapy company.  Colicy titled Colient Services" ersonnel furnishing tintain a liaison to assure			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 198 of 241

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157653	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI 09/14	
NAME OF F	PROVIDER OR SUPPLIEF		635 S S	ADDRESS, CITY, STATE, ZIP CO STATE RD 67 ESVILLE, IN 46158	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	following the co The physician w / her approval fo	alert physician to				
	Manager" indica with physicians, professionals [th services], clients	oolicy titled "RN Case ated," Collaborates other health care aerapists supportive s, and families in apprehensive, coordinated				
	of Client Service assessment, the assessment, the analysis of the inclinical manage personnel furnishmaintain a liaison efforts are coord support the object Plan of Care. The formal care confusion complete, currently and verbal interaction will assupply updating / change communicating of the same services.	policy titled Coordination as indicated, "After initial admitting Registered at shall discuss the antial visit with the ar to ensure All thing services shall an to assure that their ainated effectively and actives outlined in the anis may be done through are Plans; and written action The Primary at Care Plan and actives outlined in the action and active and written action are plans; an				
		r changes. The physician				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 199 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  09/14/2015	
NAME OF I	PROVIDER OR SUPPLIEF		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	for that change i physician to cha	d when his / her approval s necessary and to alert nges in client condition.			
	Services indicate consult and colla registered nurse The therapist wi implementing the	ed, " The therapist will aborate with the who is the case manager.			
	Communicates p physician and to and other Agenc plan, written pro	plans and changes to the nursing Case Manager y Staff through the care			
N 0546 Bldg. 00	services are limited purposes of practices setting, the register following:  (G) Inform the phappropriate medicate patient's conducted the patient and fail and related needs	(1)(G) Except where and to therapy only, for the home health ered nurse shall do the special personnel of changes in the still personnel of ch			
	Based on record	review and interview,  I to ensure that the	N 0546	1. Administrator/designee will	10/16/2015

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 200 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CC UILDING	ONSTRUCTION	COMPL		
AND PLAN	OF CORRECTION	157653	B. W		00	09/14/	
		157055	Б. W			09/14/	2015
NAME OF I	PROVIDER OR SUPPLIEF	t .			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				STATE RD 67 ESVILLE, IN 46158		
	1				E3VILLE, IIV 40130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		e had notified the		1710	complete a patient complaintform		DATE
	1				when receiving a complaint.		
		oordinated services with a			(On-going)		
	speech therapist in relation to a patient's				2. All complaint forms will be given	1	
	difficulty to swa	llow and weight loss for			to Administrator sameday to revie		
	1 of 4 records re	viewed. (#16)			contact person(s) making complain	ıt,	
	Findings include				document conversation and and and and and and and and and an		
	1. Clinical record number 16, SOC (start of care), for certification period 03/19/15 to 05/17/15 and 05/18/15 to 07/16/15				3. Patient records requested to be		
					mailed will be mailedcertified mail		
					return receipt requested. (On-goin	g)	
					4. DON/designee will notify		
	with orders for s	killed nursing, physical			patient/family same day it	1.	
	and occupational therapy services.				isdetermined agency cannot provid a discipline. (On-going)	ae	
	a. The patie	ent's clinical record was			5. DON/designee will notify MD		
	reviewed on 09/	14/15. The discharge			same day it is determinedagency		
		skilled nursing facility			cannot provide a discipline.		
	1	indicated the patient had			(On-going)		
	-	•			6. DON/designee will review all		
		ration pneumonia due to			admissions to ensure agencycan provide ordered disciplines and that	at	
	dysphagia and h	ad been receiving speech			all ordered disciplines are schedule		
	therapy during h	is / her inpatient stay.			(On-going)		
	The summary al	so indicated that the			7. When agency uses a staffing		
	patient was bein	g discharged from home			agency to cover a	AII	
	with speech ther	apy as a physician order			disciplineDON/designee will tract a communications with the staffing	111	
	_	ndicated as such.			agency to ensurethere is timely		
		ndicated as such.			follow up. (On-going)		
					8. When a staffing agency is used,		
	b. Review of	of the skilled nursing			DON/designee will contactstaffing		
	notes indicated t	he following:			agency daily, Mon-Fri, for coordination of care. All contact w	:11	
					bedocumented in the appropriate	III	
	1. 04/08	8/15: " SN [skilled			patient's chart. (On-going)		
		ed and reviewed with pt			9. If patient/caregiver declines		
	03	chin down when eating			therapy services, DON/designeewi	II	
	[ [patient] tucking	ciiii down when eating			contact patient/family no later tha	n	
					next business day to confirm		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 201 of 241

	OF CORRECTION	IDENTIFICATION NUMBER:	, ,	ULTIPLE CO UILDING	00	COMPL	
		157653	B. W	ING		09/14/	/2015
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN					STATE RD 67 ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	-SVILLE, IN 40130		(V5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	VTE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ATE.	DATE
		t stated had coughing			theydeclined therapy. Conversation	1	
	•	ng while eating breakfast.			will be documented in appropriate patient'schart. (On-going)		
	_	multivitamin in half and			10. DON/designee will in-service		
	take with ensure while SN watched patient tuck in chin " The visit note				professional on requirementto		
					contact all disciplines involved in patient's care and document name		
	failed to evidence	ee that the physician had			ofperson spoke with along with dat	:e	
		d patient needs were			and time. (On-going)		
	coordinated with	a speech therapist.	11. DON/designee will in-service staff on requirement tonotify MD of				
					changes in patient's condition and		
	2. 04/17/15: " Instructed pt on				document in patient's chart.		
	ways to prevent	aspiration and encourage			(On-going) 12. DON/designee will ensure	e all	
	patient to tuck in	chin when swallowing			disciplinesinvolved in patient's	3	
	and using thicke	ning with liquids "			care will participate in case conference. (On-going)		
	The visit note fa	iled to evidence that the			(e.i. ge.i.g)		
	physician had be	een notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
		0/15: " SN instructed pt					
		echniques, thickening of					
		visit note failed to					
		e physician had been					
	notified and pati						
	coordinated with	a speech therapist.					
		4/15: " Instructed pt on					
	thin tuck when drinking and eating SN						
	_	hydration nutrition and					
	thickening of flu	iids " The visit note					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 202 of 241

	OF CORRECTION	IDENTIFICATION NUMBER:	lì í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL	
		157653	B. W	ING		09/14/	/2015
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN					TATE RD 67 ESVILLE, IN 46158		
(X4) ID	T	TATEMENT OF DEFICIENCIES		ID	10 1122, 114 10 100		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		te that the physician had					
		d patient needs were					
	coordinated with	a speech therapist.					
	5 05/0	7/15: " CN instructed at					
		7/15: " SN instructed pt					
	on ways to improve swallowing tuck in chin when taking meds [medications]						
	fluids food " The visit note failed to						
	evidence that the physician had been						
	notified and patient needs were						
	coordinated with a speech therapist.						
	coordinated with a speech therapist.						
	6. 05/1:	5/15: Recertification					
	reassessment inc	licated the patient had a					
	functional limita	tion of swallowing,					
	safety measures	/ precautions of					
	aspiration and th	at. Physical and					
	occupational the	rapy was on hold for					
	re-evaluation aft	er the speech therapist					
	was to help with	swallowing, increase					
	nutrition, and in	crease strength. The					
	patient was recen	rtified to home health					
	care with skilled	nursing, aide and speech					
	therapy. The ski	illed nurse instructed and					
	reviewed with pa	atient ways to help					
	decrease aspirati	on. The skilled nurse					
	educated patient	/ family on dosage of					
	thick it [powder	substance to be added to					
	fluids to increase	e thickness] to be placed					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 203 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	l í	JETIPLE CO JILDING	NSTRUCTION 00	COMPL	
		157653	B. WI	NG		09/14	/2015
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RN2U IN					TATE RD 67 ESVILLE, IN 46158		
(X4) ID	T	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	tification Summary					
		tient's appetite has been					
	decreased and speech therapy was to see						
	the patient for swallowing concerns. The						
	skilled nurse indicated she had						
	coordinated with physician, physical,						
	occupational, and speech therapy but did						
	not specify who the clinicians were.						
	- 06/20/47						
	7. 06/30/15: " SN had pt eat						
	banana, glass of OJ [orange juice] and ate						
	1	of cream of wheat then					
		oughing spell, unable to					
		m of wheat pt to warm					
		about an hour and try to					
	finish " The v	visit note failed to					
		e physician had been					
	notified and	patient needs were					
	coordinated with	a speech therapist.					
	0 01 111						
		ed nursing discharge					
	1	ted " Summary of Care					
		e by Discharging					
	•	for eval [evaluation] and					
		ent CV [cardiovascular] /					
		y] / GI [gastrointestinal] /					
	GU [genitourina	* -					
		assess [assessment]					
	appetite wgt [we	eight] loss (failure to					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 204 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMI	PLETED 4/2015	
NAME OF P	PROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CO STATE RD 67 ESVILLE, IN 46158	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
PREFIX	thrive) Patient Problems swallo liquids down, even thickener. Wgt I pounds Dischar Instructions: Conthickening. Eat a firequent meals Drink at least 3 thickener "The evidence that the notified and patic coordinated with 2. The Administrator started the review the patient Administrator started the patient's administrator was explain why speciment by the produced by the produced in the pordered by the produced in the pordered by the produced in th	cy Must be preceded by full LSC IDENTIFYING INFORMATION)  Condition at Discharge: wing, keeping food, en though using loss past 2 weeks, 6 arge Planning / Int [continue] to use sm [small] freq snack thought day.  A Ensure daily with the visit note failed to entire the physician had been ent needs were a a speech therapist.  The attendant and proceeded to the street and performed the street and performed the street and she had performed the st	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	COMPLETION
		or stated the case d in the patient's case agency.				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 205 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		ſ ′	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
NAME OF P	ROVIDER OR SUPPLIER			635 S S	DDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	indicated, "All p services shall ma that their efforts effectively and s outlined in the P done through for maintaining com Plans; and writte The Primary N responsibility fo Care Plan and co caregivers within following the co The physician w / her approval fo	ersonnel furnishing aintain a liaison to assure are coordinated upport the objectives lan of Care. This may be rmal care conferences; uplete, current Care en and verbal interaction Nurse will assume r updating / changing the ommunicating changes to a twenty - four [24] hours inference or changes. ill be contacted when his r that change is alert physician to					
N 0560 Bldg. 00	Manager" indicate with physicians, professionals [the services], clients developing a couplan of care "  410 IAC 17-14-1(I Scope of Services)	mprehensive, coordinated					
Diuy. VV		ome health agency shall					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 206 of 241

	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CC JILDING	ONSTRUCTION 00	(X3) DATE COMPL	
	2. 2014.2011011	157653	B. W		<u></u>	09/14/	
		107000		CTDEET	ADDRESS, CITY, STATE, ZIP CODE	00/11/	2010
NAME OF I	PROVIDER OR SUPPLIER				STATE RD 67		
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES			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	DEFICIENCY)		DATE
	therapist assistant physical therapist 25-27-1; or (2) an occupation occupational therapist 25-27-1; or (2) an occupational therapist and occupational therapist and occupational therapist in accordance of the agency failed qualified therapist within their scoperecords reviewed.  Findings include  1. Clinical record of care), for certito 05/17/15 and a. A discharge indicated the path history of aspirar dysphagia. The indicated the path of the path occupancy	apist assistant supervised all therapist in accordance guage pathologist or ordance with IC 25-35.6. review and interview, do to ensure that a st was providing services be of practice for 1 of 4 d.  Example 16, SOC (start iffication period 03/19/15 05/18/15 to 07/16/15.  The summary from a facility dated 03/17/15, iient had a past medical tion pneumonia and physician's assessment eumonia was resolved a aspiration risk	N 0	560	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to reviev contact person(s) making complaint document conversation andsign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and tha all ordered disciplines are schedule (On-going) 7. When agency uses a staffing agency to cover a disciplineDON/designee will tract at communications with the staffing	t, ;) e t d.	10/16/2015

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 207 of 241

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  157653			UILDING	00	COMPL 09/14/	ETED	
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	•	
(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)	ATE	(X5) COMPLETION DATE
	b. A signed 03/17/15, indicated 03/17/15, indicated discharged home services.  c. Occupation indicated the following of today. Pt c/o [consumation of the consumation	B/15: " Pt doing fair omplained of] difficulty [R [Occupational ered] educated pt [Se] / daughter on need for the thickened liquids. Dtr [A won't drink anything] [Se secondary] taste. [Se ded premixed thickened ing / Training: [Se nique - chin tuck & secondary] taste.			agency to ensurethere is timely follow up. (On-going)  8. When a staffing agency is used, DON/designee will contactstaffing agency daily, Mon-Fri, for coordination of care. All contact wi bedocumented in the appropriate patient's chart. (On-going)  9. If patient/caregiver declines therapy services, DON/designee will contact patient/family no later than next business day toconfirm they declined therapy. Conversation will be documented in appropriate patient's chart. (On-going)  10. DON/designee will in-service professional on requirement to contact all disciplines involved in patient's care and document name of person spoke with along with datand time. (On-going)  11. DON/designee will in-service staff on requirement tonotify MD changes in patient's condition and document in patient's chart. (On-going)  12. DON/designee will ensure all disciplines involved inpatient's care will participate in case conference. (On-going)	l n	

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 208 of 241

STATEMEN	IT 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
		157653	B. W	ING		09/14/	2015
NAME OF E	PROVIDER OR SUPPLIER	2		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		· ·			STATE RD 67		
RN2U IN	С			MOORE	ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
		up the next day "	-				
		- <b></b>					
	3. 05/2	1/15: " Pt continues to					
	complain about his throat Discussed						
	importance of n	utrition and drinking					
	ensure if pt is unable to swallow and						
	cannot eat regular diet on any particular						
	day"						
	4. 05/25/15: " Pt required max						
	u/c [sic] for swallowing food to tuck his						
	chin. Pt nose wa	as running through entire					
	meal and pt kept	t coughing and spitting /					
	throwing up foo	d. Pt was very upset and					
	wouldn't finish f	food "					
	5. 05/2	6/15: " When talking to					
	pt he / she repor	ted he / she hadn't eaten					
	all day due to be	eing weak Pt required					
	mod [moderate]	/ max [maximum] v/c					
	[sic] for tucking	his /her chin when					
	swallowing P	t able to keep food down					
	this day "						
	9. 6/11/	/15: " He reported					
	waking up early	and having breakfast but					
	he was unable to	keep it down Pt					
	stated [illegible	writing] for told him /					
	her to drink thre	e ensures a day v/c					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 209 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653  A. BUILDING  B. WING		<u>00</u>	COMPLETED 09/14/2015		
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RN2U IN	С			STATE RD 67 RESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	[sic] required to	tuck chin to swallow. Pt			
	required extra tir	ne to eat due to problems			
	with swallowing	"			
	10. 06/1	14/15: " Pt took			
	medication and v/c [sic] required to tuck				
	chin on swallow	ing "			
	2. The Administrator was interviewed on				
	09/14/15 at 2:15 PM. The Administrator				
	indicated she vaguely remembers the				
	patient and proceded to look through the				
	patient's record.	The Adminstrator			
	notified the thera	npy company several			
	times and spoke	to an agent at the therapy			
	company. Accor	rding to the			
	Adminstrator, th	e agent had indicated			
	that a speech the	rapist had attempted to			
	contact the home	e but was unsuccessful in			
	reaching the fam	ily. Then at 2:30 PM,			
	the Adminstrator	indicated she had			
	remembered that	the speech therapist was			
	with another con	npany she had contracted			
	with but doesn't	explain the lack of notes			
	and communicat	ion.			
	_	olicy titled Occupational			
	Therapy indicate				
	-	rapy assessments,			
	diagnostic tests,	skilled treatments, and			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 210 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 09/14/2015			
NAME OF I	PROVIDER OR SUPPLIEF	3	635 S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 RESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
Nora	receiving service approved Plan o				
N 0564 Bldg. 00	listed in subsectio (3) assist the phy podiatrist, dentist, evaluating level or Based on record the agency failed and occupational physician and cardifficulty to swall of 4 records referred to 1. Clinical record of care), for cert to 05/17/15 and with orders for sand occupational a. A dischart skilled nursing findicated the pathistory of aspiral dysphagia. The indicated the profession of the pathistory of the profession of	The appropriate therapist on (b) of this rule shall: resician, chiropractor, or optometrist in a function; review and interview, do to ensure that physical latherapy had notified the ase manager of a patient's allow and weight loss for eviewed. (#16)  Example 16, SOC (start infication period 03/19/15 05/18/15 to 07/16/15 okilled nursing, physical latherapy services.  The appropriate therapist on the shall: reviewed, or optometrical interview, and interview, and interview, and interview, and interviewed. (#16)  The appropriate therapist on the shall: reviewed, or optometrical interview, and interview, and interview, and interviewed. (#16)  The appropriate therapist on the shall: reviewed, or optometrical interviewed, or optometrical	N 0564	1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be giver to Administrator sameday to revie contact person(s) making complain document conversation andsign/date form. (On-going) 3. Patient records requested to be mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify patient/family same day it isdetermined agency cannot provide a discipline. (On-going) 5. DON/designee will notify MD same day it is determinedagency cannot provide a discipline. (On-going) 6. DON/designee will review all admissions to ensure agencycan provide ordered disciplines and the all ordered disciplines are schedule (On-going) 7. When agency uses a staffing	n w, nt, ng) de
	indicated the pneumonia was resolved but remains high aspiration risk secondary to dysphagia. Diet at			· ·	eu.

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 211 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		` ´	UILDING	DNSTRUCTION  00	(X3) DATE COMPL <b>09/14</b> /	ETED		
NAME O	DF PROVIDER OR SUPPLIEI	2		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	.TE	(X5) COMPLETION DATE	
	nectar thickened caregiver to reference information liquids. The surpatient was to be speech therapy.  b. A signed 03/17/15, indicated discharged homoservices.  c. Occupation indicated the following. OT the therapist Regists [patient] / [spourpt [patient] / [spourpt [patient]] to us [daughter] states with thickener 2 OTR recomment liquids Teach Swallowing tech [and] thickener in failed to evidence case manager has	8/15: " Pt doing fair omplained of] difficulty 'R [Occupational ered] educated pt se] / daughter on need for e thickened liquids. Dtr s he won't drink anything * [* secondary] taste. ded premixed thickened			disciplineDON/designee will tract al communications with the staffing agency to ensurethere is timely follow up. (On-going)  8. When a staffing agency is used, DON/designee will contactstaffing agency daily, Mon-Fri, for coordination of care. All contact will bedocumented in the appropriate patient's chart. (On-going)  9. If patient/caregiver declines therapy services, DON/designee will contact patient/family no later than next business day toconfirm they declined therapy. Conversation will be documented in appropriate patient's chart. (On-going)  10. DON/designee will in-service professional on requirementto contact all disciplines involved in patient's care and document name ofperson spoke with along with datand time. (On-going)  11. DON/designee will in-service staff on requirement tonotify MD ochanges in patient's condition and document in patient's chart. (On-going)  12. DON/designee will ensure all disciplines involved inpatient's care will participate in case conference. (On-going)	e f		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 212 of 241

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		NSTRUCTION 00	(X3) DATE COMPL	
		157653	B. WING			09/14/	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RN2U IN					TATE RD 67 SVILLE, IN 46158		
(X4) ID	•	TATEMENT OF DEFICIENCIES	<u> </u>				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	speech therapist.						
	2 04/24	5/15: " Pt reported pain					
		ble with swallowing.					
		t on drinking thickened					
	1	ng bites of crushed up					
meds in applesauce or pudding and							
taking small amounts of meds. Pt							
reported taking a pill one day and							
coughing it back up the next day "The							
visit note failed to evidence that the							
	physician and ca	se manager had been					
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					
	2 04/20	2/15					
		2/15 note indicated pt was					
		swallowing. The visit					
		idence that the physician er had been notified and					
		ere coordinated with a					
	speech therapist.						
	specen merapist.						
	4. 05/12	2/15 note indicated the					
	patient was havi	ng difficulty swallowing					
	secondary to we	akness. The patient's					
	pain level was a	6 on a scale from one to					
	10 with 10 being	g the worse. The patient					
	also had complain	ined of neck and throat					
	being sore, swall	lowing difficulties and					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 213 of 241

	OF CORRECTION	F CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  B. WING		COMPLETED 09/14/2015	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RN2U IN	С			STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	thick congestion	" The visit note			
	failed to evidenc	e that the physician and			
	case manager ha	d been notified and			
	patient needs we	re coordinated with a			
	speech therapist.				
	5. 05/19 at the neck and the	9/15: " Pain level 4/5 hroat, decrease			
endurance " The visit note failed to					
evidence that the physician and case					
	manager had bee	n notified and patient			
	needs were coord	dinated with a speech			
	therapist.				
	complain about himportance of numerouse if pt is uncannot eat regular day" The visithat the physician been notified and	nis throat Discussed attrition and drinking able to swallow and ar diet on any particular it note failed to evidence in and case manager had a speech therapist.			
	7. 05/25 u/c [sic] for swal chin. Pt nose wa meal and pt kept	5/15: " Pt required max lowing food to tuck his as running through entire coughing and spitting /			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 214 of 241

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT A. BUILI		NSTRUCTION 00	(X3) DATE COMPL	
		157653	B. WING			09/14/	
NAME OF I	PROVIDER OR SUPPLIER	}	S	TREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RN2U IN		•			TATE RD 67 SVILLE, IN 46158		
	1	TATEMENT OF DEFICIENCIES		D I	SVILLE, IN 40130		(V5)
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)	16	DATE
		food. Discussed pt					
	1	later due to lack of					
		to the neck at a level 5					
		ote failed to evidence that					
		d case manager had been					
	notified and pati						
	coordinated with	a speech therapist.					
		6/15: " When talking to					
pt he / she reported he / she hadn't eaten							
all day due to being weak Pt required							
	mod [moderate] / max [maximum] v/c						
		his /her chin when					
	_	t able to keep food down					
	this day " The	e visit note failed to					
	evidence that the	e physician and case					
	manager had bee	en notified and patient					
	needs were coor	dinated with a speech					
	therapist.						
		/15: " He reported					
	1	and having breakfast but					
		keep it down Pt					
		writing] for told him /					
		e ensures a day v/c					
	1	tuck chin to swallow. Pt					
	_	me to eat due to problems					
	1	g " The visit note					
	failed to evidence	ee that the physician and					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 215 of 241

		IDENTIFICATION NUMBER: 157653	A. BUILDING 00 B. WING		COMPLETED 09/14/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С			STATE RD 67 ESVILLE, IN 46158		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	case manager ha	d been notified and				
	patient needs we	re coordinated with a				
	speech therapist.					
	10. 06/1 medication and we chin on swallow failed to evidence case manager had patient needs we speech therapist.  11. 06/1 difficulty Speech therapist.  Pt is continuing the difficulty swallow potential d/t [due slow to progress out with what little has nutritional deas well " The	4/15: " Pt took  /c [sic] required to tuck  ing " The visit note  e that the physician and d been notified and re coordinated with a				
		n notified and patient				
	-	dinated with a speech				
	therapist.	1				
	-	therapy notes indicated				
	the following:					
	1. 05/05	5/15: " Pt [patient]				
	reports increase	coughing and choking on				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 216 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157653	B. Wl	ING		09/14/	/2015	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE			
RN2U IN	С		635 S STATE RD 67 MOORESVILLE, IN 46158					
(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)	TE	DATE	
	food / meds "	The visit note failed to						
		e physician and case						
		en notified and patient						
		dinated with a speech						
	therapist.							
	2 05/0	7/15: " Pt reports have						
		not eating well " The						
		to evidence that the						
		se manager had been						
	notified and pati	•						
		a speech therapist.						
	3. 05/1	1/15: " Pt having						
	difficulty progre	ssing due to decrease						
	nutrition intake.	" The visit note failed						
	to evidence that	the physician and case						
	manager had bee	en notified and patient						
	needs were coor	dinated with a speech						
	therapist.							
	4 05/1	4/15: " Pt reports						
		preparation of food with						
	_	as finishing bowl of						
		when PT [physical						
		sent. He / she appeared to						
	1 111	omited it all back up. Pt						
	1 -	I difficulty with nutrition						
	_	ote failed to evidence that						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 217 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157653	B. W			09/14/		
NAME OF L	DDOMNER OF CURRY TER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER		635 S STATE RD 67					
RN2U IN				<u> </u>	ESVILLE, IN 46158			
(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)	TE	DATE	
	the physician and	d case manager had been						
	notified and pati	ent needs were						
	coordinated with	a speech therapist.						
	5. 05/25	5/15: " Pt seated in						
	kitchen and finis	shed with breakfast. Pt is						
	coughing and sp	itting in trash can "						
	The visit note far	iled to evidence that the						
	physician and ca	se manager had been						
	notified and pati	ent needs were						
	coordinated with	a speech therapist.						
	6. 06/10	6/15: " Pt reports cont						
	difficulty with sv	wallowing and choking.						
	Pt appears to have	ve lost weight and						
	appears malnour	rished Pt's strength						
	decreased slightl	ly possibly due to lack of						
	nutrition Spee	ch: See ST [speech						
	103/	wing: See ST " The						
	visit note failed	to evidence that the						
		se manager had been						
	notified and pati	ent needs were						
	coordinated with	a speech therapist.						
		8/15: " Pt drank						
		e juice and had difficulty						
	-	coughing " The visit						
	note failed to evi							
	physicianand cas	se manager had been						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 218 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING 00  B. WING			COMPLETED 09/14/2015		
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				TATE RD 67 ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
	notified and pati	ent needs were					
	coordinated with	a speech therapist.					
		2/15: " Reports not					
		not eating due to					
	_	e visit note failed to					
		e physician and case					
	manager had bee	en notified and patient					
		dinated with a speech					
	therapist.						
	0 06/24	5/15. II Dt won outs mot					
		5/15: " Pt reports not a diff [difficulty] to					
	_	s pt is so weak. Pt					
	•	aten in days Pt's skin					
		very frail and weak. Pt					
		uclty] making progress nourishment. Pt is very					
		e " The visit note					
		te that the physician and					
		• •					
	_	d been notified and are coordinated with a					
	speech therapist.						
	specen merapist.						
	10. 06/3	30/15: " Pt in kitchen					
	with nurse eating	g with encouragement.					
	Pt still coughing	with eating / swallowing					
	pt doing well	and presents better after					
	-	rt ER [emergency room]					
		<del>-</del>					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 219 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			JETIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157653	B. WII		<u></u>	09/14/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF				TATE RD 67		
RN2U IN	С		MOORESVILLE, IN 46158				
(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		rease weakness and		IAG			DATE
		e visit note failed to					
	1	e physician and case					
		en notified and patient					
	1	dinated with a speech					
	therapist.	amatea with a specen					
	merapist.						
	2 The Adminis	trator was interviewed on					
	09/14/15 at 11:4						
		ated she vaguely					
	remembered the	patient and proceeded to					
	review the patien						
		ated she had performed					
	the patient's adm						
		as not able to answer nor					
		ech therapy was not					
		patient's case when it was hysician at discharge.					
		or stated the case					
		ed in the patient's case					
	_	agency. During this					
	time, the Admin	istrator emailed and					
	called the contra	cted therapy company					
	_	s for the coordinator to					
	return her phone	call.					
	3. On 09/14/15	ot 1:52 DM the					
		at 1.33 PM, the					
		by company. The					
	Administrator ha						
		the contracted therapy					
		ed that a speech therapist					
	had made contac	et with the spouse in July					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 220 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING B. WING	00	COMPLETED 09/14/2015				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE COMPLETION	ON		
	patient was "too Administrator st did not go out to that assessment Administrator st who the speech to communication provided by Emplaide / office wor Employee N wro of therapy comp therapy], ST had times with no reference [doctor] notified interviewed at the did not remember therapist was and the speech therapist was and the physician office day and time the the physician.  4. The complaint 09/14/15 at 2:40 stated that the paragivers were the patient would therapy. The constaff would notifice informed the off difficulty with sweethers.	ated the speech therapist see the patient to make judgment and the ated she did not know therapist was. A mote dated 03/26/15, was ployee N, a home health ker, during this time. It is to emplay the many of the						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 221 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157653	B. W.	ING		09/14/	/2015	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
RN2U IN			635 S STATE RD 67 MOORESVILLE, IN 46158					
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	•	not getting speech therapy						
	for some of the s	-						
	_	eech therapists. The						
	•	ed no one had called and						
		r was any speech therapy						
	services had bee	icated how he / she						
	•	was by a therapist that						
		e and was discussing						
		. The complainant stated						
		otten so weak that he /						
	-	a skilled nursing facility						
	receiving speech	therapy.						
	•	ng inside the agency at						
	r r	lministrator stated that						
		pist was not provided by						
	the said therapy							
		note dated 03/26/15 that						
		l provided / indicated, but						
		pist was provided therapy company.						
	unough another	шегару сотрану.						
	6 An undated n	olicy titled Plan of Care						
		essional staff shall						
	promptly alert th	ne physician to any						
	changes that sug	gest a need to alter the						
	Plan of Care	11						
	7. An undated n	olicy titled Coordination						
	•	es indicated, " The						
		e contacted when his / her						
	1 2	t change is necessary and						
	approvarior illai	change is necessary and						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 222 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		157653	B. W	B. WING 09/			
C OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			635 S S	STATE RD 67		
RN2U IN	С			MOORI	ESVILLE, IN 46158		
(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 APPROPRIAT DEFICIENCY)		1
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCE	DATE	
		to changes in client					
	condition "						
N 0567	410 IAC 17-14-1(d						
D	Scope of Services						
Bldg. 00		The appropriate therapist n (b) of this rule shall:					
		nsult with the family and					
	· ·	agency personnel;					
	Based on record	review and interview,	N 0	567	going)	10/16/201	5
	physical and occ	upational therapy failed			2. All complaint forms will be given		
		patient needs were met by			to Administrator sameday to review		
	•	vices with a speech			contact person(s) making complaint	,	
	therapist in relati	•			document conversation		
	•	llow and weight loss for			andsign/date form. (On-going)		
	1 of 4 records re	•			Patient records requested to be mailed will be mailedcertified mail		
	1 01 4 lecolus le	viewed. (#10)			return receipt requested. (On-going)	1	
	TO: 1: : 1 1				4. DON/designee will notify	'	
	Findings include	:			patient/family same day it		
					isdetermined agency cannot provide	<u>;</u>	
		d number 16, SOC (start			a discipline. (On-going)		
	//	fication period 03/19/15			5. DON/designee will notify MD		
	to 05/17/15 and 0	05/18/15 to 07/16/15			same day it is determinedagency		
	with orders for s	killed nursing, physical			cannot provide a discipline.		
	and occupational	therapy services.			(On-going)		
					6. DON/designee will review all admissions to ensure agencycan		
	a. A dischar	ge summary from a			provide ordered disciplines and that	:	
	skilled nursing fa	acility dated 03/17/15,			all ordered disciplines are scheduled		
	_	ient had a past medical			(On-going)		
	_	tion pneumonia and			7. When agency uses a staffing		
		physician's assessment			agency to cover a		
	, , ,	eumonia was resolved			disciplineDON/designee will tract all		
	but remains high				communications with the staffing		
	_	-			agency to ensurethere is timely		
	secondary to dys				follow up. (On-going)		
	_	echanical soft diet with			8. When a staffing agency is used, DON/designee will contactstaffing		
	nectar thickened	liquids, and for patient /			DOM/designee will contactstalling		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 223 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CO. LDING	NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or conditions	157653	B. WIN		00	09/14/	
		107 000	<u> </u>	CTDEET A	DDDECC CITY CTATE 7ID CODE	00/11/	2010
NAME OF I	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67				
RN2U IN	С		MOORESVILLE, IN 46158				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	r to speech therapist with			agency daily, Mon-Fri, for coordination of care. All contact wil	ı	
		n on nectar thickened			bedocumented in the appropriate	ı	
	•	nmary indicated the			patient's chart. (On-going)		
	-	e discharged home with			9. If patient/caregiver declines		
	speech therapy.				therapy services,DON/designee will		
					contact patient/family no later than	ı	
	_	prescription dated			next business day toconfirm they declined therapy. Conversation will		
	•	ted the patient was to be			be documented in		
		e with speech therapy			appropriatepatient's chart.		
	services.				(On-going)		
					10. DON/designee will in-service		
	•	onal therapy notes			professional on requirementto		
	indicated the following	lowing:			contact all disciplines involved in		
					patient's care and document name ofperson spoke with along with dat	۵	
	1. 04/08	8/15: " Pt doing fair			and time. (On-going)	C	
	today. Pt c/o [co	omplained of] difficulty			11. DON/designee will in-service		
	swallowing. OT	R [Occupational			staff on requirement tonotify MD o	f	
	Therapist Regist	ered] educated pt			changes in patient's condition and document in patient's chart.		
	[patient] / [spous	se] / daughter on need for			(On-going)		
	pt [patient] to us	e thickened liquids. Dtr			12. DON/designee will ensure all		
	[daughter] states	he won 't drink			disciplines involved inpatient's care		
		ickener 2* [* secondary]			will participate in case conference. (On-going)		
	taste. OTR reco	mmended premixed					
	thickened liquids	s Teaching / Training:					
	Swallowing tech	nique - chin tuck &					
	[and] thickener r	needs " The visit note					
	failed to evidence	e that the patient needs					
	were coordinated	d with a speech therapist.					
	2 04/24	5/15: " Pt reported pain					
		• •					
	in neck and troul	ble with swallowing.					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 224 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING 00  B. WING			COMPLETED 09/14/2015		
NAME OF F	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С		635 S STATE RD 67 MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Educated patient	on drinking thickened					
	liquids after taki	ng bites of crushed up					
	meds in applesau	ace or pudding and					
	taking small amo	ounts of meds. Pt					
	reported taking a	pill one day and					
	coughing it back	up the next day "The					
	visit note failed t	to evidence that the					
	patient needs we	re coordinated with a					
	speech therapist.						
	3. 04/22	2/15 note indicated pt was					
	having difficulty	swallowing. The visit					
	note failed to evi	idence that the patient					
	needs were coord	dinated with a speech					
	therapist.						
	4. 05/12	2/15 note indicated the					
	patient was havi	ng difficulty swallowing					
	secondary to wea	akness. The patient's					
	pain level was a	6 on a scale from one to					
	10 with 10 being	the worse. The patient					
	also had complain	ined of neck and throat					
	being sore, swall	lowing difficulties and					
	-	" The visit note					
	_	e that the patient needs					
		d with a speech therapist.					
		- •					
	5. 05/19	9/15: " Pain level 4/5					
	at the neck and t	hroat, decrease					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 225 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	IULTIPLE CO UILDING	00	(X3) DATE COMPL			
		157653	B. W			09/14/		
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
		•	635 S STATE RD 67 MOORESVILLE, IN 46158					
RN2U IN		TATEMENT OF DEFICIENCIES		<u> </u>	=5VILLE, IIN 40150		(7/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE	
		The visit note failed to						
		e patient needs were						
	coordinated with	a speech therapist.						
		1/15: " Pt continues to						
	_	his throat Discussed						
	•	itrition and drinking						
	_	able to swallow and						
	_	ar diet on any particular						
	_	it note failed to evidence						
	•	eeds were coordinated						
	with a speech the	erapist.						
	7 05/0	5/15 H D						
		5/15: " Pt required max						
		llowing food to tuck his						
		as running through entire						
		coughing and spitting /						
		d. Pt was very upset and						
		food. Discussed pt						
		later due to lack of						
		to the neck at a level 5						
		te failed to evidence that						
	-	s were coordinated with a						
	speech therapist.							
	8 05/26	5/15: " When talking to						
		ted he / she hadn't eaten						
	_	ing weak Pt required						
	-	/ max [maximum] v/c						
		[						

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 226 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILDING 00  B. WING			COMPLETED 09/14/2015		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	С				STATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	[sic] for tucking	his /her chin when					
	swallowing Pt	able to keep food down					
	this day " The	e visit note failed to					
	evidence that the	patient needs were					
	coordinated with	a speech therapist.					
	waking up early he was unable to	15: " He reported and having breakfast but keep it down Pt writing] for told him /					
	her to drink three	e ensures a day v/c					
	[sic] required to	tuck chin to swallow. Pt					
	required extra tir	me to eat due to problems					
	with swallowing	" The visit note					
	failed to evidenc	e that the patient needs					
	were coordinated	d with a speech therapist.					
	medication and vector on swallow failed to evidence	14/15: " Pt took 1/c [sic] required to tuck 1/c [sic]					
	difficulty Spec Pt is continuing to difficulty swallow potential d/t [due	19/15: " Swallowing ech slow, garbled (wet), to have weight loss and wing. Pt has met max eto] these barrier. Pt is and states he gets worn					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 227 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		A. BUILD B. WING	A. BUILDING 00  B. WING			COMPLETED 09/14/2015	
NAME OF I	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67				
RN2U IN	С				ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	out with what lit	tle he currently does. Pt					
	has nutritional de	eficits affecting progress					
	as well " The	e visit note failed to					
	evidence that the	e patient needs were					
	coordinated with	a speech therapist.					
	d. Physical	therapy notes indicated					
	the following:	.,					
	1 05/04	5/15. " Dt [motiont]					
		5/15: " Pt [patient]					
	•	coughing and choking on					
		The visit note failed to					
		e patient needs were					
	coordinated with	a speech therapist.					
	2. 05/07	7/15: " Pt reports have					
	lost weight and r	not eating well " The					
	visit note failed t	to evidence that the					
	patient needs we	ere coordinated with a					
	speech therapist.						
	3. 05/11	1/15: " Pt having					
		ssing due to decrease					
		" The visit note failed					
		the patient needs were					
		a speech therapist.					
	A 05/1	1/15: " Dt raparta					
		4/15: " Pt reports					
	confusion over p	preparation of food with					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 228 of 241

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157653		l ′	JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>09/14</b> /	ETED	
RN2U IN	ROVIDER OR SUPPLIEF			635 S S	NDDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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)	TE	(X5) COMPLETION DATE
		as finishing bowl of					
	cream of wheat when PT [physical therapy] present. He / she appeared to						
	•	omited it all back up. Pt					
	_	l difficulty with nutrition					
		ote failed to evidence that					
	the patient needs were coordinated with a						
	speech therapist.						
	5. 05/25/15: " Pt seated in						
	kitchen and finished with breakfast. Pt is						
	coughing and sp	itting in trash can "					
	The visit note fa	iled to evidence that the					
	_	ere coordinated with a					
	speech therapist.						
	6. 06/10	6/15: " Pt reports cont					
	-	wallowing and choking.					
		ve lost weight and					
		rished Pt's strength					
		ly possibly due to lack of					
	_	ech: See ST [speech					
		owing: See ST " The to evidence that the					
		ere coordinated with a					
	speech therapist.						
	specen merapist.	•					
	7. 06/18	8/15: " Pt drank					
		e juice and had difficulty					
		•					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 229 of 241

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
		157653	B. W	ING		09/14	/2015
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		1	DDRESS, CITY, STATE, ZIP CODE		
RN2U IN	C				TATE RD 67 ESVILLE, IN 46158		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	coughing " The visit					
		idence that the patient					
		dinated with a speech					
	therapist.						
	0.06/0	0/17 II D					
		2/15: " Reports not					
	_	not eating due to					
	_	e visit note failed to e patient needs were					
		a a speech therapist.					
	coordinated with	i a speech therapist.					
	9 06/2:	5/15: " Pt reports not					
		n diff [difficulty] to					
		s pt is so weak. Pt					
	_	aten in days Pt's skin					
		very frail and weak. Pt					
	having diff [diff]	iuclty] making progress					
	due to decreased	l nourishment. Pt is very					
	weak at this time	e " The visit note					
	failed to evidence	e that the patient needs					
	were coordinated	d with a speech therapist.					
	10. 06/.	30/15: " Pt in kitchen					
	with nurse eating	g with encouragement.					
	Pt still coughing	with eating / swallowing					
	pt doing well	and presents better after					
	IV fluids for sho	ort ER [emergency room]					
	visit. Pt still inc	rease weakness and					
	fatigue " The	e visit note failed to					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 230 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653  A. BUILDING  00  B. WING		COMPLETED 09/14/2015			
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE TATE RD 67		
RN2U IN	С			ESVILLE, IN 46158		
(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)	TE	(X5) COMPLETION DATE
		patient needs were				
	coordinated with	a speech therapist.				
	on 09/14/15 at 1 Administrator staremembered the review the patier Administrator stathe patient's adm Administrator was explain why specinvolved in the pordered by the plate The Administrator manager involver retired from the attime, the Administrator that the called the contractions of the state of the	patient and proceeded to nt's record. The ated she had performed aission. The as not able to answer nor each therapy was not eatient's case when it was hysician at discharge. For stated the case d in the patient's case agency. During this istrator emailed and cted therapy company is for the coordinator to				
	Administrator has coordinator from company indicat had made contact but the services was "too	ad a return call from the by company. The ad stated that the a the contracted therapy ed that a speech therapist t with the spouse in July was declined due to the far gone." The				
		ated the speech therapist see the patient to make				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 231 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653  A. BUILDING  00  B. WING			COMPLETED 09/14/2015	
NAME OF F	PROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Administrator stawho the speech to communication in provided by Emplaide / office work Employee N wro of therapy compatherapy], ST had times with no reteled interviewed at the did not remember therapist was another speech therapy stated that the pacaregivers were the patient would therapy. The constaff would notified informed the official through the state of	note dated 03/26/15, was ployee N, a home health ker, during this time. Ite "According to [Name any] ST [speech called numberous [sic] urn call to ST. Dr.  "Employee N was is time and stated she r who the speech dishe did not know who pist spoke with at the and did not know what speech therapist notified  ant was contacted on PM. The complainant tient and family cold upon admission that die getting speech mplainant stated that the sy the office often and face of the patient's each that they (patient and so) were not aware that ot getting speech therapy			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 232 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO ЛLDING	NSTRUCTION 00	(X3) DATE COMPI	
		157653	B. WI	ING		09/14	/2015
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			TATE RD 67 ESVILLE, IN 46158		
RN2U IN		TATEMENT OF DEFICIENCIES		<u> </u>	55 VILLE, IN 40 150		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE
		r was any speech therapy					
	services had bee						
		icated how he / she					
		was by a therapist that					
		e and was discussing  The complainant stated					
		gotten so weak that he /					
		a skilled nursing facility					
	receiving speech						
5. Upon returning inside the agency at							
	2:55 PM, the Administrator stated that						
		pist was not provided by					
	the said therapy						
		note dated 03/26/15 that I provided / indicated, but					
		pist was provided					
		therapy company.					
	5	1 3					
	6. An undated p	oolicy titled					
	"Coordination of	f Client Services"					
	indicated, " A	ll personnel furnishing					
	services shall ma	aintain a liaison to assure					
	that their efforts	are coordinated					
	effectively and s	support the objectives					
	outlined in the P	lan of Care. This may be					
	done through for	rmal care conferences;					
	maintaining com	plete, current Care					
	Plans; and writte	en and verbal interaction					
	The physician	will be contacted when					
	his / her approva	al for that change is					
	necessary and to	alert physician to					
	l		1				I

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 233 of 241

AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER: 157653	A. BUILDING B. WING	00	COMPLETED 09/14/2015
NAME OF I	PROVIDER OR SUPPLIER		635 S S	ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 ESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) C condition "	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
N 0579 Bldg. 00	do the following: (7) Act as a constagency personnel. Based on record to ensure that the notified the phys of a patient's diffiweight loss for 1 (#16)  Findings include  1. Clinical record of care), for certification of care, for certification of care, and consistency food secondary] swall she really doesn't	The social worker shall  ultant to other home health review, the agency failed e social worker had dician and case manager ficulty to swallow and of 4 records reviewed.  It describes the ficulty to swallow and of 4 records reviewed.  It describes the ficulty to swallow and of 4 records reviewed.  It describes the ficulty to swallow and of 4 records reviewed.  It describes the ficulty to swallow and of 4 records reviewed.  It describes the ficulty to swallow and of 4 records reviewed.  It describes the ficulty to swallow and of 4 records reviewed on worker visit note dated the reason for visit:  In the ficulty to swallow and of 4 records reviewed on worker visit note dated the reason for visit:  In the ficulty to swallow and of 4 records reviewed on worker visit note dated the reason for visit:  In the ficulty to swallow and of 4 records reviewed.	N 0579	1. DON/designee will in-service professional staff on requirement notify DON/designee and MD of changes in patient condition.  Communication tobe documented patient's chart. (On-going)  2. DON/deisgnee will audit 10% of documentation weekly toensure documented changes in patient's condition has been reported to M (On-going)	ed in  of  any

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 234 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653  A. BUILDING B. WING		00	COMPLETED 09/14/2015			
NAME OF P	ROVIDER OR SUPPLIER		635 S	T ADDRESS, CITY, STATE, ZIP CODE STATE RD 67 RESVILLE, IN 46158		
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	swallowing and	then laying down "				
	The visit note fai	led to evidence that the				
physician and case manager had been						
	notified.					
	"Assisting with a concerns Pt [p since last visit or energy level is possible all" The visit that the physician been notified.  3. An undated p indicated, "Profe promptly alert the changes that sug Plan of Care"  4. An undated p Therapy indicated plans and change nursing Case Ma Staff through the	atient] is visibly smaller in 6/3. States his / her bor and not eating well at it note failed to evidence in and case manager had  olicy titled Plan of Care ssional staff shall ie physician to any gest a need to alter the  olicy titled Occupational id, " Communicates is to the physician and to inager and other Agency is care plan, written indigard participation in care				
N 0608	410 IAC 17-15-1(a Clinical Records	n)(1-6)				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 235 of 241

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CO ILDING	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	157653	B. WI		00	COMPL 09/14/	
		157655	D. W1			09/14/	2015
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RN2U IN	^				STATE RD 67 ESVILLE, IN 46158		
KNZU IIV			_	WOORE	=5 VILLE, IN 40 150		
(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 CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	Rule 15 Sec. 1(a) containing pertiner findings in accordary professional stand for every patient a (1) The medical appropriate identiff (2) Name of the chiropractor, podia (3) Drug, dietary orders.  (4) Signed and contributed to by a Clinical notes shal is rendered and in (14) days.  (5) Copies of surperson responsible component of the (6) A discharge shaded on record the agency failed clinical record we contained all accomportation in the	Clinical records Int past and current Ince with accepted Ince with acc	N 00		1. Administrator/designee will complete a patient complaintform when receiving a complaint. (On-going) 2. All complaint forms will be given to Administrator sameday to review contact paragraph.		10/16/2015
	•	1 2			contact person(s) making complaint	,	
	_	gency, physician, and			document conversation andsign/date form. (On-going)		
	with the patient /	family members.			3. Patient records requested to be		
	Findings include				mailed will be mailedcertified mail return receipt requested. (On-going 4. DON/designee will notify	)	
	1. Clinical recor	d number 16, SOC (start			patient/family same day it		
	of care), for certi	fication period 03/19/15			isdetermined agency cannot provide	9	
	to 05/17/15 and 0	05/18/15 to 07/16/15.			a discipline. (On-going) 5. DON/designee will notify MD		
	2. The patient's clinical record was				same day it is determinedagency		
	•	14/15. The discharge			cannot provide a discipline.		
		skilled nursing facility			(On-going)		
	summary month a	skined nursing facility	1		6. DON/designee will review all		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 236 of 241

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
		157653	B. W	ING		09/14/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			STATE RD 67		
RN2U IN	C				ESVILLE, IN 46158		
						,	
(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)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG			DATE
	· · · · · · · · · · · · · · · · · · ·	indicated the patient had			admissions to ensure agencycan		
	a history of aspiration pneumonia due to				provide ordered disciplines and that		
	dysphagia and had been receiving speech				all ordered disciplines are scheduled	1.	
	therapy during h	is / her inpatient stay.			(On-going) 7. When agency uses a staffing		
	This discharge s	ummary had indicated			agency to cover a		
		o be discharged home			disciplineDON/designee will tract all		
	^	apy services. A signed			communications with the staffing		
	_	ed 03/17/15 indicated the			agency to ensurethere is timely		
	1 *				follow up. (On-going)		
	_	ave speech therapy at			8. When a staffing agency is used,		
	home.				DON/designee will contactstaffing		
					agency daily, Mon-Fri, for		
	3. A recertificat	ion assessment dated			coordination of care. All contact will		
	05/15/15, indica	ted the patient had a			bedocumented in the appropriate		
	functional limita	tion of swallowing,			patient's chart. (On-going)		
	safety measures	•			9. If patient/caregiver declines		
	*	that physical and			therapy services, DON/designee will		
	_	rapy was on hold for			contact patient/family no later than		
		* *			next business day to confirmthey		
		er speech therapist was			declined therapy. Conversation will		
	_	llowing, increase			be documented in appropriate patient'schart. (On-going)		
		crease strength Recert			10. DON/designee will in-service		
	l *	[home health care] with			professional on requirementto		
	SN, aide and spe	eech therapy. SN	1		contact all disciplines involved in		
	instructed and re	eviewed with patient			patient's care and document name		
	ways to help dec	crease aspiration SN			ofperson spoke with along with date	9	
	educated patient	/ family on dosage of			and time. (On-going)		
	_	substance to be added to			11. DON/designee will in-service		
		e thickness] to be placed			staff on requirement tonotify MD of	:	
		Recertification Summary			changes in patient's condition and		
	_	_	1		document in patient's chart.		
	indicated " Pt ap		1		(On-going)		
		n to see pt for swallowing			12. DON/designee will ensure all		
	concerns. SN in				disciplines involved inpatient's care		
	coordinated with	n MD [physician], PT			will participate in case conference.		
	[physical therapy	y], OT [occupational			(On-going)		
	'	eech therapy], and HHA			13. DON/designee will in-service		
			1		professional on requirementto		

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 237 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	00	(X3) DATE SURVEY  COMPLETED
		157653	B. WING		09/14/2015
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•
RN2U IN	С			STATE RD 67 RESVILLE, IN 46158	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDENCENT AN OF CONDECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	who the clinician	le] but did not specify		notify DON when patient cannot b evaluated within 48 hours of order	
				(On-going)	
	4. Employee N				
		PM. Employee N			
		l not know who she had			
	_	thought she had			
		es and times that she had			
	_	speech therapist.			
Employee N indicated she would get notification from therapy by email and					
evaluations would be sent to the office by					
		N indicated if there was			
		needed, she would type it			
	up.				
		strator was interviewed			
	on 09/14/15 at 1				
		ated she vaguely			
		patient and proceeded to			
	review the patien				
	the patient's adm	ated she had performed			
	_	as not able to answer nor			
		ech therapy was not			
		patient's case when it was			
	_	hysician at discharge.			
		or stated the case			
	manager involve	ed in the patient's case			
	retired from the	agency. During this			
	time, the Admin	istrator emailed and			
	called the contra	cted therapy company			
	_	es for the coordinator to			
	return her phone	call.			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 238 of 241

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653		l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/14/	ETED	
	PROVIDER OR SUPPLIER	3		635 S S	ADDRESS, CITY, STATE, ZIP CODE TATE RD 67 ESVILLE IN 46158		
NAME OF I RN2U IN (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR  3. On 09/14/15 Administrator has contracted theray Administrator has coordinator from company indicated had made contact but the services patient was "too Administrator steed did not go out to that assessment Administrator steed who the speech communication provided by Emaide / office wor Employee N wro of therapy compatherapy], ST has times with no real [doctor] notified interviewed at the did not remember 1.	at 1:53 PM, the ad a return call from the py company. The ad stated that the n the contracted therapy are that a speech therapist of with the spouse in July was declined due to the		635 S S		ATE	(X5) COMPLETION DATE
	the speech thera physician office day and time the the physician.  4. The complain 09/14/15 at 2:40	pist spoke with at the and did not know what e speech therapist notified nant was contacted on PM. The complainant attent and family					

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 239 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157653  A. BUILDING  00  B. WING		00	COMPLETED 09/14/2015		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE STATE RD 67	
RN2U IN	С			ESVILLE, IN 46158	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	caregivers were the patient would therapy. The constaff would notifinformed the offidifficulty with swomplainant state family caregivers the patient was nown for some of the sthemselves as spromplainant state left messages now services had been complainant indiviscovered this work came to the home physical therapy the patient had go she was now in a receiving speech.  5. Upon returning 2:55 PM, the Add the speech therapy communication in Employee N had the speech therapy through another.  6 An undated posservices indicated.	told upon admission that all be getting speech implainant stated that the sy the office often and sice of the patient's avallowing. The ed that they (patient and is) were not aware that ot getting speech therapy taff portrayed eech therapists. The ed no one had called and it was any speech therapy in declined. The cated how he / she was by a therapist that e and was discussing. The complainant stated often so weak that he / it skilled nursing facility therapy.			

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 240 of 241

PRINTED: 12/21/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
157653		B. WING		09/14/2015		
NAME OF PROVIDER OR SUPPLIER  RN2U INC			STREET ADDRESS, CITY, STATE, ZIP CODE 635 S STATE RD 67 MOORESVILLE, IN 46158			
(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 OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	[24] hours of vis	sit."				

State Form Event ID: 78MQ11 Facility ID: 012905 If continuation sheet Page 241 of 241