

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	<p>This was a federal home health recertification survey. This was a partial extended survey</p> <p>Survey dates: 12/28/15 - 1/5/16</p> <p>Facility: 011123</p> <p>Medicare #: 157592</p> <p>Medicaid #: 200857640</p> <p>Skilled unduplicated census: 64 patients</p>	G 0000		
G 0121 Bldg. 00	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on home visit observation, interview, record review, and interview, the agency failed to ensure all employees (Employee E, Home Health Aide) followed agency policies related to infection control for 1 of 5 home visit observations (patient #5).</p> <p>The findings include:</p>	G 0121	<p>The Administrator and Director of Nursing have reviewed the Standard, 484.12 (c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD, and reviewed the Agencies Policies on Infection Control, hand Hygiene, Standard Precautions, and bag technique. The Administrator and Director of Nursing have discussed with employee E about the home visit</p>	02/26/2016

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/05/2016
NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 0158 Bldg. 00	<p>1. On 12/30/15 at 10:10 AM, Employee E, home health aide, date of hire 9/25/15 and first patient contact 10/20/15, was observed to wash her hands in the patient #5's bathroom before caring for patient #5. She was observed to turn on the faucets with her hands and then dry her hands with the patient's towel hanging on a towel rack. She then took toilet paper from the toilet paper dispenser and turned off the faucets.</p> <p>On 12/30/15 at 11 AM, Employee A, the director of nursing indicated the handwashing procedure was not followed by Employee E.</p> <p>2. The agency policy and procedure titled "Policy and Procedure for Hand Washing" with no date stated, "Home Health Care Agency Staff members will follow hand washing procedure ... Procedure: 1. Wet hands with running water ... Pat hands dry, beginning at the wrist and moving downward. 6. Turn off water faucet using paper towel on faucets."</p>		findings and observations of the Surveyor Agency policies were reviewed with employee E who has verbalized understanding and has also performed a return demonstration. The home health aides will be in-serviced on 2/26/16 by the Administrator and Director of nursing. The in-service will include infection control, hand washing and bag technique. The Director of Nursing will be responsible for the maintenance and compliance in accordance with the policies and procedures for infection control of communicable disease by requiring all field employees to perform an annual return demonstration on hand washing, bag technique, and standard precautions.		
	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on record review, observation, and interview, the agency failed to ensure services had been provided in accordance with the plan of care / physician orders in 4 of 13 records reviewed (#1, 8, 9, 10).</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 9/22/15 and diagnosis of muscle weakness, included a plan of care for the certification period of 11/21/15 - 1/19/16. The plan of care included orders for the skilled nurse (SN) to visit one times a week for 9 weeks to assess pain every visit; to assess joints for stiffness, tenderness, mobility, pain, and range of motion; teach patient / caregiver blood pressure medications; to assess patient filling medication box to determine if patient is filling correctly; skilled nurse to assess caregiver filling medication box to determine if caregiver is preparing correctly. Skilled nurse visits occurred on 11/28/15, 12/5/15, and 12/13/15.</p> <p>A. There was no skilled nurse completed between 12/20/15 - 12/26/15. The visit note was blank.</p>	G 0158	<p>G158: The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the standard, 484.18, Acceptance of Patients, Plan of care, and Medical Supervision that care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatric medicine. Further, reviewing agency policies on scope of services. Ongoing assessments and the Skilled Nurses Job Description. The Administrator and Director of Nursing have further discussed with all employees reviewing the standard and agency policies to ensure this deficiency does not recur with employees as care services of the agency are to be provided in accordance with the patient's plan of care that is established and reviewed by the physician. 1A) All staff were instructed on missed visit policy and to notify Director of nursing if missed visit occurred. Quality Assurance audit will be done weekly to ensure visits made. Director of nursing responsible for auditing charts weekly for skilled nursing visits. 1B) Employee D, RN instructed on Policy of Care Plan. Employee D verbalized understanding to follow Plan of care and check all patients' medication and check and see if</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 12/29/15 at 10:10 AM, the director of nursing stated, "That would be a missed visit because I am not sure if this visit occurred or not." The director of nursing indicated Employee M, Registered Nurse (RN) , had quit and had not completed all of the paperwork.</p> <p>B. At a home visit observation on 12/29/15 at 12:20 PM, Employee D, RN, failed to assess patient or caregiver filling the medication box.</p> <p>On 12/29/15 at 3:45 PM, the director of nursing indicated the medication box filling was not assessed.</p> <p>2. Clinical record #8, SOC 10/21/15 and diagnosis of generalized muscle weakness, included a plan of care for the certification period of 10/21/15 - 12/19/15. This plan of care included orders for the physical therapist to assess, evaluate, and establish plan of care. Other orders for physical therapy included to visit 1 times a week for one week and then to visit 2 times a week for 6 weeks and to assess kegel training.</p> <p>A. A physical therapy evaluation dated 11/6/15 with a time in of 2 PM and time out of 3 PM failed to evidence the</p>		<p>patient or caregiver is filling medication box correctly. 2) Physical Therapist for clinical record # 8 was instructed on following Plan of care and to assess Kegel training and document, therapist verbalized understanding. 3) Skilled Nurses for clinical record # 9 was instructed to follow plan of care and document weekly weights and teach on disease process of dementia, she verbalized understanding. 4) Skilled Nurse instructed on clinical record # 10 to follow plan of care and to test blood sugar each visit and to assess caregiver filling medication box. Skilled Nurse verbalized understanding. All skilled nurses & physical therapist were in-serviced on the Plan of Care Policy on 02/26/2016. Staff re-educated on how to view Plan of Care via Electronic medical record, and instructed to follow Plan of Care when completing skilled nurse visits. Staff also instructed on how to update Plan of Care to insure high quality care. The Director of Nursing will monitor compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient's kegel training was assessed.</p> <p>B. Physical therapy visits on 11/10/15, 11/12/15, 11/24/15, 12/1/15, 12/3/15, 12/8/15, 12/10/15, and 12/15/15. There was no kegel training assessed at any of these visits.</p> <p>C. On 1/4/16 at 1:30 PM, the director of nursing indicated the kegel training was not assessed as ordered on the plan of care.</p> <p>3. Clinical record #9, SOC 6/5/15 and diagnosis of hypertensive heart failure without heart failure, included a plan of care for the certification period of 12/2/15 - 1/30/16. This plan of care included orders for the skilled nurse to visit once a week and to complete weekly weights and to teach the disease process of dementia to include pathophysiology, signs and symptoms, treatment and exacerbation. Skilled nurse visits occurred on 12/4/15, 12/11/15, 12/18/15, 12/25/15, and 1/1/16. The skilled nurse did not complete the weights or teach disease process for dementia at any of these visits.</p> <p>On 1/4/16 at 1:10 PM, the director of nursing indicated the plan of care was not followed at these visits.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4. Clinical record #10, SOC 2/12/15 and diagnosis of pressure ulcer stage 2, included a plan of care for the certification period of 10/10/15 - 12/8/15. This plan of care included orders for the skilled nurse to visit once a week and to include blood sugar testing at each visit and to assess caregiver filling medication box to determine if caregiver is preparing correctly. At skilled nurse visits on 10/12/15, 10/21/15, 10/26/15, and 11/2/15, these tasks were not completed.</p> <p>On 1/4/16 at 2:30 PM, the director of nursing indicated these tasks had not been completed at visits.</p> <p>5. The agency policy titled "Plan of Care" with a date of 2008 stated, " Purpose ... to provide guidelines for agency staff develop a plan of care individualized to meet specific identified needs ... to assure that the plan meets state / federal guidelines and all applicable laws and regulations."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure the plan of care was signed by the primary care physician in a timely manner for 1 of 13 records reviewed (#11).</p> <p>Findings</p> <p>1. Clinical record # 11, start of care (SOC) 3/6/15 and diagnosis of hypertension, included a plan of care for the certification period of 9/2/15 - 10/31/15. This plan of care failed to show a timely physician signature. The signature was dated 10/20/15.</p> <p>2. On 12/29/15 at 3:20 PM, the director of nursing indicated the signature was a little late.</p>	G 0159	<p>G159: The Administrator and Director of Nursing and Quality Assurance Nurse have reviewed the standard, 484.18(a), Plan of Care, and company policies on Scope of Services, Admission Criteria and Process, care Planning Process, Physician participation in Plan of Care, and Verification of Physician Orders. The Administrator will utilize the Electronic Medical Record's document tracking functionality. The administrator trained the office manager on how to use this feature. Plan of Care signatures will be followed up weekly to ensure compliance. The Administrator has notified the physicians' offices and their staff after discussion, orders has been received with Continued from page 5 Physicians signature on timely basis. The Administrator will be responsible for compliance.</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0170 Bldg. 00	<p>3. The agency policy titled "Plan of Care" with a date of 2008 stated, " Purpose ... to provide guidelines for agency staff develop a plan of care individualized to meet specific identified needs ... to assure that the plan meets state / federal guidelines and all applicable laws and regulations ... An individualized plan of care signed by a physician shall be required for each patient receiving home health ... services ... signed physician orders will be obtained as quickly as possible."</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on record review, observation, and interview, the agency failed to ensure the skilled nurse had been provided services in accordance with the plan of care / physician orders in 3 of 13 records reviewed (#1, 9, 10) of patients with skilled nurse services.</p> <p>The findings include:</p>	G 0170	G170: The Administrator will in-service nursing staff that all provided services follows a written order signed by a physician. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Clinical record#1 All skilled nurses instructed on missed visit policy on 2/26/16 to inform office if visits not made to finish skilled nursing notes same day. 1B)	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Clinical record #1, start of care (SOC) 9/22/15 and diagnosis of muscle weakness, included a plan of care for the certification period of 11/21/15 - 1/19/16. The plan of care included orders for the skilled nurse (SN) to visit one times a week for 9 weeks to assess pain every visit; to assess joints for stiffness, tenderness, mobility, pain, and range of motion; teach patient / caregiver blood pressure medications; to assess patient filling medication box to determine if patient is filling correctly; skilled nurse to assess caregiver filling medication box to determine if caregiver is preparing correctly. Skilled nurse visits occurred on 11/28/15, 12/5/15, and 12/13/15.</p> <p>A. There was no skilled nurse completed between 12/20/15 - 12/26/15. The visit note was blank.</p> <p>On 12/29/15 at 10:10 AM, the director of nursing stated, "That would be a missed visit because I am not sure if this visit occurred or not." The director of nursing indicated Employee M, Registered Nurse (RN) , had quit and had not completed all of the paperwork.</p> <p>B. At a home visit observation on 12/29/15 at 12:20 PM, Employee D, RN, failed to assess patient or caregiver filling</p>		<p>Employee D instructed to assess patient or caregiver filling medication box and to follow Plan of Care. 2) Skilled nurse for clinical record #10 instructed to follow plan of care and record blood sugar every visit and to assess caregiver filling medication box to determine if caregiver is preparing correctly. Policies reviewed, skilled nurse verbalized understanding. Director of nursing will in-service all skilled nurses to follow Plan of Care and document each service rendered in accordance to the written plan of care. The Quality Assurance Committee will be responsible for auditing 10% quarterly, clinical record review to ensure compliance. The Director of Nursing will be responsible for compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the medication box.</p> <p>On 12/29/15 at 3:45 PM, the director of nursing indicated the medication box filling was not assessed.</p> <p>2. Clinical record #9, SOC 6/5/15 and diagnosis of hypertensive heart failure without heart failure, included a plan of care for the certification period of 12/2/15 - 1/30/16. This plan of care included orders for the skilled nurse to visit once a week and to complete weekly weights and to teach the disease process of dementia to include pathophysiology, signs and symptoms, treatment and exacerbation. Skilled nurse visits occurred on 12/4, 12/11, 12/18/15, 12/25/15, and 1/1/16. The skilled nurse did not complete the weights or teach the disease process of dementia at any of these visits.</p> <p>On 1/4/16 at 1:10 PM, the director of nursing indicated the plan of care was not followed at these visits.</p> <p>3. Clinical record #10, SOC 2/12/15 and diagnosis of pressure ulcer stage 2, included a plan of care for the certification period of 10/10/15 - 12/8/15. This plan of care included orders for the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0186 Bldg. 00	<p>skilled nurse to visit once a week and to include blood sugar testing at each visit and to assess caregiver filling medication box to determine if caregiver is preparing correctly. At skilled nurse visits on 10/12/15, 10/21/15, 10/26/15, and 11/2/15, these tasks were not completed.</p> <p>On 1/4/16 at 2:30 PM, the director of nursing indicated these tasks had not been completed at visits.</p> <p>4. The agency policy titled "Skilled Nursing Services" with no date stated, "Purpose ... to abide by state / federal guidelines and offer guidelines to the agency staff ... the registered nurse ... initiates the plan of care."</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)</p> <p>Based on record review and interview, the agency failed to ensure the physical therapist (Employee C) completed the patient's physical therapy evaluation for 2</p>	G 0186	The Administrator and Director of Nursing have reviewed the Standard 484.32 Therapy services. The administrator and Director of nursing have discussed with (Employee C)	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of 8 records reviewed of patients receiving physical therapy (#7 and #8).</p> <p>The findings include:</p> <p>1. Clinical record #7, start of care (SOC) 12/5/15 and diagnosis of unilateral primary osteoarthritis of the right hip, included a plan of care for the certification period of 12/5/15 - 2/2/16. This plan of care included orders for the patient for physical therapy to evaluate and treat the patient. The therapy evaluation occurred on 12/9/15 and was not complete as evidenced by the following:</p> <p>A. A physical therapy evaluation dated 12/9/15 with a time in of 1:45 PM and time out of 2:35 PM failed to evidence the patient's physical assessment included shoulder extension, abduction, interior and exterior rotations, elbow extension, finger flexion and extension, wrist flexion and extension, hip extension and abduction, knee extension, ankle plantar and dorsiflexion, trunk rotation and extension, and a neck assessment. This evaluation or assessment was completed by Employee C, Physical Therapist.</p> <p>B. On 1/4/16 at 4 PM, the director of nursing indicated the Employee C had</p>		<p>physical therapist about the physical therapy evaluation and reviewed "Therapy Services" policy. The physical therapist was instructed to complete all assessments completely, she verbalized understanding. Director of Nursing and quality assurance nurse will be responsible to audit all physical therapy evaluation and notes for completeness to ensure assessments are completed accurately and completely. The Director of Nursing is responsible for compliance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>not fully completed the physical therapy evaluation noted at the visit on 12/9 with patient #7.</p> <p>2. Clinical record #8, SOC 10/21/15 and diagnosis of generalized muscle weakness, included a plan of care for the certification period of 10/21/15 - 12/19/15. This plan of care included orders for the physical therapist to evaluate and treat this patient. The therapy evaluation occurred on 11/6/15 and was not complete as evidenced by the following:</p> <p>A. A physical therapy evaluation dated 11/6/15 with a time in of 2 PM and time out of 3 PM failed to evidence the patient's physical assessment included a shoulder, elbow, finger, and wrist evaluation. This evaluation / assessment was completed by Employee C, physical therapist.</p> <p>B. On 1/4/16 at 12:50 PM, the director of nursing indicated Employee C had not fully completed the physical therapy evaluation for patient #8 at the visit on 11/6.</p> <p>C. On 1/4/16 at 1:25 PM, Employee C, physical therapist indicated the therapy evaluation could be more complete.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G 0321 Bldg. 00	<p>3. The agency policy titled "Therapy Services" with no date stated, "After the assessment is completed, the therapist will communicate specific treatments and modalities to be used."</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. Based on record review and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completing an assessment in 1 of 2 closed records reviewed of patients who received skilled services and had required comprehensive assessments. (#6). The findings include: 1. Clinical record #6 included a recertification assessment completed by the director of nursing and Registered Nurse (RN) Employee A on 10/10/15. A. ISDH documents evidenced a recertification assessment completed on 10/10/15 but not transmitted until</p>	G 0321	The Administrator and Director of nursing have reviewed the standard 484.20(a) Encoding Oasis Data. Policies and procedures were reviewed Director of nursing will be responsible to ensure all documents are exported in accordance with Federal regulations, and to ensure Oasis date have been transmitted within 30 days of completion and assessment.	02/26/2016
--------------------	--	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0340 Bldg. 00	<p>11/27/15.</p> <p>B. An agency validation transmittal validation report for patient #6 stated, "Oasis C1 Certification date ... assessment date 10/10/15 ... Episode 10/15/15 - 12/13/15 ... Exported 11/27/15.</p> <p>2. On 1/4/16 at 4:30 PM, the director of nursing indicated the oasis submission was completed late.</p> <p>3. The agency policy titled "Encoding and Reporting OASIS Data" with a date of 2009 stated, "The agency will electronically report all OASIS data collected in accordance with federal regulation."</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Based on record review and interview, the agency failed to ensure comprehensive assessments completed upon the patient's return home from in-patient facilities were complete and accurately reflected the patient's status in 1 of 5 active records reviewed of patients who had resumptions of care (#1).</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Clinical record #1 included a resumption of care visit completed by the RN, Employee M, on 12/13/15. This resumption of care visit evidenced the patient had a functional limitation of ambulation, the patient was homebound, was unable to dress self, was able to transfer with minimal human assistance or with use of an assistive device, used a cane, and needed help with ambulation. 2. At a home visit observation on 12/29/15 at 12:10 PM, patient #1 was observed to ambulate without difficulty and did not need a cane or other assistive device. 3. On 12/29/15 at 12:30 PM, patient #1 indicated driving a car and completing activities of daily living independently including dressing self. Patient #1 indicated never having a cane. 	G 0340	<p>The Administrator and Director of nursing have been reviewed the Standard 484.55(d)(2) Update of the comprehensive assessment. Employee M did ROC on 12/13/15 on visit 12/29/15 did not need cane stated she was driving only to church 1 times a week down street. But no evidence of driving, because it had snowed that day and no tracks on driveway. Patient has new skilled nurse, patient was discharged per SN. All skilled nurses in- serviced Medicare Benefit Policy Manual Chapter 7 section 30.1.1. Skilled nurses verbalized understanding. Director of nursing will be responsible for compliance to ensure homebound status. Director of nursing will make periodic visits and phone calls to ensure homebound status. Skilled nurses instructed to document in their notes any changes of Continued from Page 12 condition or any improvements in condition to determined if discharge planning can be initiated and patient can be discharged. Administrator will be responsible for compliance</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0000 Bldg. 00	<p>4. On 12/29/15 at 3:45 PM, the director of nursing indicated the resumption of care was not accurate.</p> <p>This was a state home health relicensure survey.</p> <p>Survey dates: 12/28/15 - 1/5/16</p> <p>Facility: 011123</p> <p>Medicare #: 157592</p> <p>Medicaid #: 200857640</p> <p>Skilled unduplicated census: 64 patients</p>	N 0000		
N 0456 Bldg. 00	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Based on record review and interview, the administrator failed to ensure 1 of 1 agency developed, implemented, maintained, and evaluated a quality assessment and performance improvement program that reflected the complexity of the home health organization and services creating the potential to affect all of the agency's 64 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence the agency developed, implemented, maintained, and evaluated a quality assessment and performance improvement program that reflected the complexity of the home health organization and services 2. On 1/5/16 at 11:05 AM, the administrator indicated the agency failed to take action that resulted in improvement across the spectrum of care. She indicated improvement was needed since the plan was not complete and the implementation of the plan was not complete. 	N 0456	<p>N 456: The Administrator had a meeting on 2/15/16 with the Director of Nursing, clinical records review committee, the professional advising committee and the quality assurance staff. The quality improvement program and quality improvement plans. The clinical review committee will report overall findings, analyze summarized report improved inter disciplinary communication and kept record of any implementation in order to maintained and improved overall patient care. The Administrator will be responsible for compliance. The home health agency has developed implemented, maintained and evaluated a quality assessment and performance improvement program. The Director of nursing will ensure the ongoing quality assurance program has designed objective measures to improve patient care. A written plan was instituted to</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0470 Bldg. 00	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on home visit observation, interview, record review, and interview, the agency failed to ensure all employees (Employee E, Home Health Aide) followed agency policies related to infection control for 1 of 5 home visit observations (patient #5).</p> <p>The findings include:</p> <p>1. On 12/30/15 at 10:10 AM, Employee E, home health aide, date of hire 9/25/15 and first patient contact 10/20/15, was observed to wash her hands in the patient #5's bathroom before caring for patient #5. She was observed to turn on the faucets with her hands and then dry her hands with the patient's towel hanging on a towel rack. She then took toilet paper from the toilet paper dispenser and turned off the faucets.</p> <p>On 12/30/15 at 11 AM, Employee A,</p>	N 0470	<p>improve quality of care.</p> <p>N 470: Employee E, Home Health Aide was in- serviced one on one by the Director of Nursing, on Infection Control, proper hand washing technique on 1/5/16. The home health aides will be in-serviced on 2/19/16 by the Administrator and Director of nursing. The in-service will include infection control, hand washing and bag technique. The Administrator will be responsible to monitor all corrective actions to ensure that this deficiency does not occur again. Ongoing monthly in-services with all home health aides will occur.</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0472 Bldg. 00	<p>the director of nursing indicated the handwashing procedure was not followed by Employee E.</p> <p>2. The agency policy and procedure titled "Policy and Procedure for Hand Washing" with no date stated, "Home Health Care Agency Staff members will follow hand washing procedure ... Procedure: 1. Wet hands with running water ... Pat hands dry, beginning at the wrist and moving downward. 6. Turn off water faucet using paper towel on faucets."</p> <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on record review and interview,</p>	N 0472	N 472: The Administrator had a meeting on 2/15/16 with the Director of Nursing, clinical	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the administrator failed to ensure 1 of 1 agency developed, implemented, maintained, and evaluated a quality assessment and performance improvement program that reflected the complexity of the home health organization and services creating the potential to affect all of the agency's 64 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records failed to evidence the agency developed, implemented, maintained, and evaluated a quality assessment and performance improvement program that reflected the complexity of the home health organization and services 2. On 1/5/16 at 11:05 AM, the administrator indicated the agency failed to take action that resulted in improvement across the spectrum of care. She indicated improvement was needed since the plan was not complete and the implementation of the plan was not complete. 		<p>records review committee, the professional advisory committee and the quality assurance staff. The quality improvement program and quality improvement plans were reviewed by the professional advisory committee. The clinical review committee will report overall findings, analyze summarized report improved interdisciplinary communication and keep record of any implementation in order to maintain and improve overall patient care to the professional advisory committee. The Administrator will be responsible for compliance. Continued from page 3 The home health agency has developed, implemented, maintained and evaluated a quality assessment and performance improvement program. The Administrator will ensure the ongoing quality assurance program has designed objective measures to improve patient care. A written plan</p> <p>was</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

N 0522 Bldg. 00	<p>410 IAC 17-13-1(a) Patient Care</p> <p>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on record review, observation, and interview, the agency failed to ensure services had been provided in accordance with the plan of care / physician orders in 4 of 13 records reviewed (#1, 8, 9, 10).</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC)</p>	N 0522	<p>institute d to improve quality of care.</p> <p>N 522: The Director of Nursing had a mandatory in service with all nurses and therapists on proper assessments and documentation to include the information from the plan of care (POC). The skilled nursing notes and physical therapy notes will be checked weekly by the payroll staff</p>	02/26/2016
--------------------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>9/22/15 and diagnosis of muscle weakness, included a plan of care for the certification period of 11/21/15 - 1/19/16. The plan of care included orders for the skilled nurse (SN) to visit one times a week for 9 weeks to assess pain every visit; to assess joints for stiffness, tenderness, mobility, pain, and range of motion; teach patient / caregiver blood pressure medications; to assess patient filling medication box to determine if patient is filling correctly; skilled nurse to assess caregiver filling medication box to determine if caregiver is preparing correctly. Skilled nurse visits occurred on 11/28/15, 12/5/15, and 12/13/15.</p> <p>A. There was no skilled nurse completed between 12/20/15 - 12/26/15. The visit note was blank.</p> <p>On 12/29/15 at 10:10 AM, the director of nursing stated, "That would be a missed visit because I am not sure if this visit occurred or not." The director of nursing indicated Employee M, Registered Nurse (RN) , had quit and had not completed all of the paperwork.</p> <p>B. At a home visit observation on 12/29/15 at 12:20 PM, Employee D, RN, failed to assess patient or caregiver filling the medication box.</p>		<p>and QA nurse for completion of notes. The nursing notes include a head to toe assessment and are to be completed by the skilled nurse each visit, and to follow the plan of care. The agency reviewed the Clinical Documentation policy. If skilled nursing notes are found to be incomplete, they will be returned for the nurse to complete. The QA supervisor will review the nursing progress notes for documentation and completion and follow up as needed. The nursing progress notes will be checked weekly for accuracy and completeness.</p> <p>Continued from Page 4 All staff in serviced on missed visit policy 2/19/16. Employee D, RN in serviced on following the plan of care and to assess patient or caregiver filling medication box, physical therapist were instructed to follow plan of care. All skilled nurses & physical therapist were in-serviced on the Plan of Care Policy. Staff re-educated on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 12/29/15 at 3:45 PM, the director of nursing indicated the medication box filling was not assessed.</p> <p>2. Clinical record #8, SOC 10/21/15 and diagnosis of generalized muscle weakness, included a plan of care for the certification period of 10/2/15 - 12/19/15. This plan of care included orders for the physical therapist to assess, evaluate, and establish plan of care. Other orders for physical therapy included to visit 1 times a week for one week and then to visit 2 times a week for 6 weeks and to assess kegel training.</p> <p>A. A physical therapy evaluation dated 11/6/15 with a time in of 2 PM and time out of 3 PM failed to evidence the patient's kegel training was assessed.</p> <p>B. Physical therapy visits on 11/10/15, 11/12/15, 11/24/15, 12/1/15, 12/3/15, 12/8/15, 12/10/15, and 12/15/15. There was no kegel training assessed at any of these visits.</p> <p>C. On 1/4/16 at 1:30 PM, the director of nursing indicated the kegel training was not assessed as ordered on the plan of care.</p> <p>3. Clinical record #9, SOC 6/5/15 and</p>		<p>how to view Plan of Care via Electronic medical record, and instructed to follow Plan of Care when completing skilled nurse visits. Staff also instructed on how to update Plan of Care to insure high quality care</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>diagnosis of hypertensive heart failure without heart failure, included a plan of care for the certification period of 12/2/15 - 1/30/16. This plan of care included orders for the skilled nurse to visit once a week and to complete weekly weights and to teach the disease process of dementia to include pathophysiology, signs and symptoms, treatment and exacerbation. Skilled nurse visits occurred on 12/4, 12/11, 12/18/15, 12/25/15, and 1/1/16. The skilled nurse did not complete the weights or teach for dementia at any of these visits.</p> <p>On 1/4/16 at 1:10 PM, the director of nursing indicated the plan of care was not followed at these visits.</p> <p>4. Clinical record #10, SOC 2/12/15 and diagnosis of pressure ulcer stage 2, included a plan of care for the certification period of 10/10/15 - 12/8/15. This plan of care included orders for the skilled nurse to visit once a week and to include blood sugar testing at each visit and to assess caregiver filling medication box to determine if caregiver is preparing correctly. At skilled nurse visits on 10/12/15, 10/21/15, 10/26/15, and 11/2/15, these tasks were not completed.</p> <p>On 1/4/16 at 2:30 PM, the director of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0524 Bldg. 00	<p>nursing indicated these tasks had not been completed at visits.</p> <p>5. The agency policy titled "Plan of Care" with a date of 2008 stated, " Purpose ... to provide guidelines for agency staff develop a plan of care individualized to meet specific identified needs ... to assure that the plan meets state / federal guidelines and all applicable laws and regulations."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure the plan of care was signed by the primary care physician in a timely manner for 1 of 13 records reviewed (#11).</p> <p>Findings</p> <p>1. Clinical record # 11, start of care (SOC) 3/6/15 and diagnosis of hypertension, included a plan of care for the certification period of 9/2/15 - 10/31/15. This plan of care failed to show a timely physician signature. The signature was dated 10/20/15.</p> <p>2. On 12/29/15 at 3:20 PM, the director of nursing indicated the signature was a little late.</p> <p>3. The agency policy titled "Plan of Care" with a date of 2008 stated, " Purpose ... to provide guidelines for agency staff develop a plan of care</p>	N 0524	N 524: The Administrator has reviewed clinical record # 11. The Administrator will utilize the Electronic Medical Record's document tracking functionality. The administrator trained the office manager on how to use this feature. Plan of Care signatures will be followed up weekly to ensure compliance. The Administrator has notified the physicians' offices and their staff on timely submission of signature. The administrator will be responsible to ensure timely physician signature on all plan of cares.	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0537 Bldg. 00	<p>individualized to meet specific identified needs ... to assure that the plan meets state / federal guidelines and all applicable laws and regulations ... An individualized plan of care signed by a physician shall be required for each patient receiving home health ... services ... signed physician orders will be obtained as quickly as possible."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on record review, observation, and interview, the agency failed to ensure the skilled nurse had been provided services in accordance with the plan of care / physician orders in 3 of 13 records reviewed (#1, 9, 10) of patients with skilled nurse services.</p> <p>The findings include:</p> <p>1. Clinical record #1, start of care (SOC) 9/22/15 and diagnosis of muscle weakness, included a plan of care for the certification period of 11/21/15 - 1/19/16.</p>	N 0537	<p>N 537: 1. The Administrator an Director of Continued From page 8 Nursing has reviewed 410 IAC 17-14-1(a) Scope of Services. A) Clinical record # 1 was a missed visit. Employee M had quit and did not finish paperwork at time of survey. A missed visit report was filled out by QA supervisor 12/29/15. B) Employee D, RN was instructed one on one to follow plan of care and assess all patients or caregiver filling medication box.</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The plan of care included orders for the skilled nurse (SN) to visit one times a week for 9 weeks to assess pain every visit; to assess joints for stiffness, tenderness, mobility, pain, and range of motion; teach patient / caregiver blood pressure medications; to assess patient filling medication box to determine if patient is filling correctly; skilled nurse to assess caregiver filling medication box to determine if caregiver is preparing correctly. Skilled nurse visits occurred on 11/28/15, 12/5/15, and 12/13/15.</p> <p>A. There was no skilled nurse completed between 12/20/15 - 12/26/15. The visit note was blank.</p> <p>On 12/29/15 at 10:10 AM, the director of nursing stated, "That would be a missed visit because I am not sure if this visit occurred or not." The director of nursing indicated Employee M, Registered Nurse (RN) , had quit and had not completed all of the paperwork.</p> <p>B. At a home visit observation on 12/29/15 at 12:20 PM, Employee D, RN, failed to assess patient or caregiver filling the medication box.</p> <p>On 12/29/15 at 3:45 PM, the director of nursing indicated the</p>		<p>2. All nurses were in serviced on following the plan of care and weigh patient if on plan of care and teach on disease processes.</p> <p>3. Nurse for clinical record # 10 was instructed one on one to follow the plan of care and include blood sugar testing every visit and to assess caregiver filling medication box to determine if caregiver is preparing correctly. All skilled nurses were in-serviced on the Plan of Care Policy on 02/26/2016. Staff re-educated on how to view Plan of Care via Electronic medical record, and instructed to follow Plan of Care when completing skilled nurse visits. Staff also instructed on how to update Plan of Care to insure high quality care. The Director of Nursing will be responsible for compliance and check skilled nurse's notes weekly. The quality assurance nurse will return skilled nursing notes if corrections are needed. All skilled nurses were also in-serviced on how to complete missed visits via</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/05/2016	
NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>medication box filling was not assessed.</p> <p>2. Clinical record #9, SOC 6/5/15 and diagnosis of hypertensive heart failure without heart failure, included a plan of care for the certification period of 12/2/15 - 1/30/16. This plan of care included orders for the skilled nurse to visit once a week and to complete weekly weights and to teach the disease process of dementia to include pathophysiology, signs and symptoms, treatment and exacerbation. Skilled nurse visits occurred on 12/4, 12/11, 12/18/15, 12/25/15, and 1/1/16. The skilled nurse did not complete the weights or teach the disease process of dementia at any of these visits.</p> <p>On 1/4/16 at 1:10 PM, the director of nursing indicated the plan of care was not followed at these visits.</p> <p>3. Clinical record #10, SOC 2/12/15 and diagnosis of pressure ulcer stage 2, included a plan of care for the certification period of 10/10/15 - 12/8/15. This plan of care included orders for the skilled nurse to visit once a week and to include blood sugar testing at each visit and to assess caregiver filling medication box to determine if caregiver is preparing</p>		Electronic medical record.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0541 Bldg. 00	<p>correctly. At skilled nurse visits on 10/12/15, 10/21/15, 10/26/15, and 11/2/15, these tasks were not completed.</p> <p>On 1/4/16 at 2:30 PM, the director of nursing indicated these tasks had not been completed at visits.</p> <p>4. The agency policy titled "Skilled Nursing Services" with no date stated, "Purpose ... to abide by state / federal guidelines and offer guidelines to the agency staff ... the registered nurse ... initiates the plan of care."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on record review and interview, the agency failed to ensure comprehensive assessments completed upon the patient's return home from in-patient facilities were complete and accurately reflected the patient's status in</p>	N 0541	The Administrator and Director of nursing have reviewed clinical record # 1 Employee M completed a ROC 12/13/15 at time of assessment. Employee M stated patient was homebound unable to dress self, transfer with minimal assistance, needed help	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1 of 5 active records reviewed of patients who had resumptions of care (#1).</p> <p>Findings</p> <ol style="list-style-type: none"> Clinical record #1 included a resumption of care visit completed by the RN, Employee M, on 12/13/15. This resumption of care visit evidenced the patient had a functional limitation of ambulation, the patient was homebound, was unable to dress self, was able to transfer with minimal human assistance or with use of an assistive device, used a cane, and needed help with ambulation. At a home visit observation on 12/29/15 at 12:10 PM, patient #1 was observed to ambulate without difficulty and did not need a cane or other assistive device. On 12/29/15 at 12:30 PM, patient #1 indicated driving a car and completing activities of daily living independently including dressing self. Patient #1 indicated never having a cane. On 12/29/15 at 3:45 PM, the director of nursing indicated the resumption of care was not accurate. 		<p>with ambulation. On 12/29/15 patient had improved and was discharged by another Employee RN, because Employee M had resigned. All nurses in serviced 02/26/2016 on proper completion and accurately filling out ROC. Staff also in-serviced about The Medicare Benefit Policy manual Chapter 7 section 30.1.1 Patient Confined to the Home. Staff instructed on how to document homebound status. Director of nursing will make periodic visits and phone calls to ensure homebound status. Administrator will be responsible for compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0564 Bldg. 00	<p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function;</p> <p>Based on record review and interview, the agency failed to ensure the physical therapist (Employee C) completed the patient's physical therapy evaluation for 2 of 8 records reviewed of patients receiving physical therapy (#7 and #8).</p> <p>The findings include:</p> <p>1. Clinical record #7, start of care (SOC) 12/5/15 and diagnosis of unilateral primary osteoarthritis of the right hip, included a plan of care for the certification period of 12/5/15 - 2/2/16. This plan of care included orders for the patient for physical therapy to evaluate and treat the patient. The therapy evaluation occurred on 12/9/15 and was not complete as evidenced by the following:</p> <p>A. A physical therapy evaluation dated 12/9/15 with a time in of 1:45 PM and time out of 2:35 PM failed to evidence the patient's physical assessment included shoulder extension, abduction, interior and exterior rotations,</p>	N 0564	<p>N 564: The Administrator has discussed with (Employee C) physical therapist about the physical therapy evaluation and reviewed "Therapy Services" Policy. Physical therapist was instructed to assess all extremities in assessment and to complete assessment fully. Clinical record # 8 was corrected by physical therapist. All physical therapy assessments will be checked weekly by quality assurance nurse and will be returned if not complete. The Administrator is responsible for compliance.</p>	02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>elbow extension, finger flexion and extension, wrist flexion and extension, hip extension and abduction, knee extension, ankle plantar and dorsiflexion, trunk rotation and extension, and a neck assessment. This evaluation or assessment was completed by Employee C, Physical Therapist.</p> <p>B. On 1/4/16 at 4 PM, the director of nursing indicated the Employee C had not fully completed the physical therapy evaluation noted at the visit on 12/9 with patient #7.</p> <p>2. Clinical record #8, SOC 10/21/15 and diagnosis of generalized muscle weakness, included a plan of care for the certification period of 10/2/15 - 12/19/15. This plan of care included orders for the physical therapist to evaluate and treat this patient. The therapy evaluation occurred on 11/6/15 and was not complete as evidenced by the following:</p> <p>A. A physical therapy evaluation dated 11/6/15 with a time in of 2 PM and time out of 3 PM failed to evidence the patient's physical assessment included a shoulder, elbow, finger, and wrist evaluation. This evaluation / assessment was completed by Employee C, physical therapist.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157592	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LMR INDIANA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7863 BROADWAY STE 126 MERRILLVILLE, IN 46410
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>B. On 1/4/16 at 12:50 PM, the director of nursing indicated Employee C had not fully completed the physical therapy evaluation for patient #8 at the visit on 1/6.</p> <p>C. On 1/4/16 at 1:25 PM, Employee C, physical therapist indicated the therapy evaluation could be more complete.</p> <p>3. The agency policy titled "Therapy Services" with no date stated, "After the assessment is completed, the therapist will communicate specific treatments and modalities to be used."</p>			