	F OF HEALTH AND HU						RM APPROVED
	R MEDICARE & MEDIC			TINE			B NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		00	COMPL	
		157223	B. WIN	G		05/20/	2016
NAME OF I	PROVIDER OR SUPPLIE	P		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		T OF INDIANA, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
G 0000							
Bldg. 00	This was a Feder recertification a	eral home health nd complaint	G 00	00	Please see Plan of Correction beginning with tag# G108.		
	investigation su	rvev					
	Extended 5-19-	-					
	Extended 5-19-	10.					
	a 1						
	Complaint #: II	N00173876;					
	Substantiated, d	leficiencies related to the					
	complaint are ci	ited at 42 CFR 484.12(c),					
	<u>^</u>	b), 484.30, & 484.30(a).					
	-0-1.10, -0-1.10($(0), +0+.50, \mathbf{a} + 0+.50(\mathbf{a}).$					
	Survey Dates: 3 and 5-20-16.	5-17-16, 5-18-6, 5-19-16,					
	Facility #: 0059	940					
	Medicare Provi	der # 15-7223					
	Medicaid Vende	or #: N/A					
	~	e Health of Indiana was					
		of compliance with					
		articipation 42 CFR					
	484.18 Accepta	nce of Patients, Plan of					
	-	cal Supervision, 42 CFR					
		Nursing Services, and 42					
		ome Health Aide Services.					
	UFK 484.30 H0	me ricatul Alue Services.					
	ViaQuest Home	e Health of Indiana is					
	~	providing its own home					
	-	ning and/or competency					
	evaluation prog	ram for a period of two					
					1		

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

TITLE

(X6) DATE

PRINTED: 06/17/2016

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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/20/2016		
	PROVIDER OR SUPPLIE	r † of Indiana, llc		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	ΛTE	(X5) COMPLETION DATE
G 0108 Bldg. 00	found out of con of Participation Acceptance of I Medical Superv Skilled Nursing 484.36 Home H 484.36 Home H PARTICIPATE The patient has t advance about th of any changes in The HHA must a of the disciplines the frequency of furnished. The HHA must a of any change in change is made. Based on record the agency failed been informed in	hing 5-20-16 due to being mpliance with Conditions 42 CFR 484.18 Patients, Plan of Care, and rision, 42 CFR 494.30 Services, and 42 CFR lealth Aide Services. IFORMED AND the right to be informed, in the care to be furnished, and in the care to be furnished, and in the care to be furnished. dvise the patient in advance that will furnish care, and visits proposed to be dvise the patient in advance the plan of care before the d review and interview, ed to ensure patients had in advance of the ency of visits in 7 (#s 1, 2,	G 01	108	All clinical staff have been educated on the following: •The requirements of 484.10 (1) •That all patients must be	О (с)	06/15/2010
	The findings in 1. Clinical reco	of 12 records reviewed. clude: ord number 1 included an rvice Agreement" dated			informed, in advance, of the proposed frequency of visits in writing on the Admission Serv Agreement Clinical staff will include the proposed frequency visits on the Admission Servic Agreement for all patients admitted to the agency. The	ice cy of	

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BU B. WI		00	COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	r I OF INDIANA, LLC		14649 H	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH WILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF 5-4-16. The sert skilled nursing, therapy, and how were to be prov	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) vice agreement identified physical and occupational me health aide services ided. The agreement ce the proposed frequency o be provided.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIU DEFICIENCY) agency's Admission Service Agreement has been revised include a line for each discipli frequency. Each SOC will b audited, weekly for 6 weeks, to compliance threshold of 90% achieved, for the presence of proposed frequency of visits of	to ne's pe until is the
	"Home Health A Agreement" dat agreement ident physical and oct to be provided.	rd number 2 included a Admission Service ed 2-15-16. The service tifies skilled nursing and cupational therapy were The agreement failed to oposed frequency of visits			each discipline on the Admiss Service Agreement. After achieving compliance thresho audits will continue of 10% of clinical records quarterly. The Clinical Director/designed responsible for correcting this deficiency and for monitoring corrective action to ensure that this deficiency is corrected.	ld, e is the
	"Admission Ser 4-26-16. The se identified skille and occupationa be provided. Th	rd number 4 included an vice Agreement" dated ervice agreement d nursing and physical al therapy services were to ne agreement failed to oposed frequency of visits				
	start of care date failed to evidence informed of the	and number 6 evidenced a e of 3-31-16. The record ce the patient had been care to be furnished or equency of visits proposed				
		rd number 7 included a Admission Service				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Agreement" dated 11-5-15. The service agreement identified skilled nursing, physical and occupational therapy, home health aide services, and medical social services were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 6. Clinical record number 8 included an "Admission Service Agreement" dated 2-12-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 7. Clinical record number 9 included an "Admission Service Agreement" dated 4-6-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 8. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 4 of 104

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06/17/2016

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLIE		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC	EVAN	SVILLE, IN 47725		
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
G 0110 Bldg. 00	Subpart I of part to maintaining wr procedures regar The HHA must in information to the concerning its po directives, includi applicable State I advance directive at the time of the the information is provided. Based on record the agency faile been provided v applicable State advance directive 12) of 12 record The findings ind 1. Clinical record 12 evidenced th provided with th ViaQuest Home upon admission "Advance the Ind	es with the requirements of 489 of this chapter relating ritten policies and rding advance directives. form and distribute written e patient, in advance, licies on advance ing a description of law. The HHA may furnish es information to a patient first home visit, as long as a furnished before care is d review and interview, ed to ensure patients had with a description of e law with regards to ves in 12 (#s 1 through ds reviewed.	G 0110	All agency staff were educate the following: • The requirements of 484.1 (2) (ii) • That the agency must info and distribute written informato to the patient, in advance, concerning its policies on advance directives, including description of applicable Staff law before care is provided. • Agency Policy C-430 (Adv Directives) The Indiana State Department Health (ISDH) description of applicable State law, "Your R to Decide" dated July 2013 w included in all admission pactor to be provided to all patients admitted to the agency prioricare being provided. The ISE description of applicable State law, "Your Right to Decide" d	0 (c) rm tion a e ance nt of tight till be kets to)H e	06/15/2016

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

Event ID:

EDWQ11 Facility ID: IN005940

If continuation sheet Page 5 of 104

CENTERS FO	R MEDICARE & MEDI	JMAN SERVICES CAID SERVICES			ON	RM APPROVEI IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE COMPI 05/20	LETED
NAME OF	PROVIDER OR SUPPLIE	ER	STREET	ADDRESS, CITY, STATE, ZIP CODE		
		H OF INDIANA, LLC		HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID	SUMMARY	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 DEFICIENCY)	ATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	July2013 was distributed to a		DATE
		r Right To Decide" July		current patients of the agence		
	2013.			50% of admission packets wi		
				audited weekly for 6 weeks, o		
		Director indicated, on		until compliance threshold of is achieved, to ensure inclusi		
		PM, the information		the appropriate ISDH advance		
	· ·	ients with regards to		directive information. After	•	
		ves did not include the		compliance threshold is achie	eved,	
		description of applicable		auditswill continue of 10% of		
	· · · · · ·	r Right To Decide" July		admission packets quarterly. The Clinical Director/designe	e is	
	2013.			responsible for correcting this		
				deficiency and for monitoring		
		s June 2013 "Advance		corrective action to ensure th	at	
	-	icy and procedure number		this deficiency is corrected.		
	· ,	s, "During the initial visit,				
		under ViaQuest Care, the				
		provided with written				
		ncerning the patient's				
	-	te law (both statutory and				
	· · · ·	ke decisions concerning				
		ncluding the right to accept				
		al or surgical treatment				
	directives."	formulate advance				
G 0121	484.12(c)					
						
Bldg. 00	PROFESSIONAL	L STD staff must comply with				
		sional standards and				
		pply to professionals				
		vation, interview, and	G 0121	All clinical staff, including		06/19/201
		the agency failed to ensure		Employees G, K, and B will b	е	
		led care in accordance		educated on the following: •Agency Policy B-400 (Infe	ction	
	-	's own infection control		Prevention and Control Plan) supporting documentation		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOD MEDICADE & MEDICAID SEDVIC

	ENT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 157223	ì í	VILDING NG	00	(X3) DATE COMPL 05/20 /	
JAME OF	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP CODE		
/IAQUE	ST HOME HEALT	H OF INDIANA, LLC			HIGHWAY 41 NORTH VILLE, IN 47725		
X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION)		TAG			DATE
	· ·	ocedures and with the			Agency Policy B-410 (Stan	dard	
	Centers for Dis	sease Control (CDC)			Precautions for All Health CareWorkers)-see supporting		
	guidelines in 3	(#s 1, 2, & 3) of 6 home			documentation		
	visit observatio	ons completed.			·Centers for Disease Contro	ol's	
		•			(CDC) Guidelines related to	-	
	The findings in	clude:			Infection Control and Standar Precautions	d	
					•The requirements of 484.1	2 (c)	
		G, a registered nurse (RN),			– Compliance with Accepted		
		o complete an assessment			Professional	-"	
a	and dressing ch	nange on patient number 1			Standards Agency clinical st will provide care in accordance		
	on 5-18-16 at 1	0:00 AM (observation #			with the agency's infection co		
	1). The RN wa	as observed to remove the			policies and procedures and v		
	old dressing us	ing a pair of bandage			the CDC guidelines, which wi		
	•	RN removed her gloves			reviewed and distributed to al		
		er hands. The RN cleaned			clinical staff. Infection contro		
		ed to remove the old			competency of all clinical staf	fwill	
		onned clean gloves without			be re-assessed to ensure compliance with agency polic	أمو	
	-	-			and procedures and CDC	103	
	cleansing her h	lands.			guidelines related to infection		
		, , ,			control and standard precauti		
		K, an RN, was observed to			by 6/19/16. Monthly in-service		
	complete dress	ing changes to patient			will be developed, and preser	nted	
	number 2 on 5-	-18-16 at 12:15 PM			to all clinical staff, related to infection control, standard		
	(observation nu	umber 2). The RN			precautions, and related topic	S	
	cleansed her ha	ands and donned clean			Documentation will be	····	
	gloves. The RI	N removed the dressing			maintained of content and		
	-	it's left lower leg, changed			attendance. Home visits to		
	-	cleansed her hands, and			observe wound care performe	ed	
	-	he dressings from the right			by RNs will be initiated on a	-	
		RN cleansed her hands			quarterly basis, beginning with quarter 3 of 2016, for the	1	
	-				remainder of the year, in orde	r to	
	-	er gloves. The RN then			audit/review appropriate		
		ght lower leg and the left			technique, staff competency		
	-	RN failed to change her			and compliance with infection		
	gloves and clea	anse her hands between the			control policies and procedure		
	two.				These home visit audits will b	е	

EDWQ11 Facility ID: IN005940

If continuation sheet Page 7 of 104

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	A. BUII	DING	DNSTRUCTION 00	СОМ	E SURVEY PLETED
		157223	B. WIN				0/2016
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP CODE		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO) BE IPRIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	audit	DATE
		1 1, 1, 1			documented on a focused tool. Non compliance will b		
		was observed to obtain			addressed with clinicians of		
		needed for the dressing			one-to-one basis until 100	%	
	-	pilateral lower extremities.			compliant. Home visits will	then	
		served to place the clean			continue annually to	~~	
	**	ig on the floor without a			ensurecontinued complian The Clinical Director/desig		
	barrier.				be responsible for monitori		
					these corrective actions to	ensure	
		ansing the lower			that this deficiency is corre	cted.	
	extremities, the	RN cleansed her hands					
	and changed he	r gloves. The RN					
	measured the le	ft lower leg wound and					
	applied a clean	Telfa dressing. The RN					
	cleansed her ha	nds and changed her					
	gloves and appl	lied a a Kerlix wrap and					
	Coban wrap to	the left lower leg. The					
	RN then applie	d a Kerlix wrap to the					
	right lower leg	without cleansing her					
	hands or chang	ing her gloves.					
	C. The Clin	ical Director indicated, on					
		0 PM, employee K had					
		he dressing change in					
	-	h facility policy.					
	3. Employee B	, an RN, was observed to					
		ing change on patient					
	·	18-16 at 2:40 PM					
		3). The RN was observed					
		ands and obtain the					
		s from the patient's					
		N donned clean gloves					
	without cleansi						

PRINTED: 06/17/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG A. The RN was observed to apply a gel to two dressings with a gloved finger and then apply the dressings to the

wounds on the patient's buttocks. B. The Clinical Director indicated, on 5-18-16 at 3:05 PM, employee B had not performed the dressing change in accordance with facility policy. 4. The agency's June 2013 "Infection Prevention & Control Plan" policy and procedure number B-400 (C) states, "ViaQuest has developed, and implemented infection control practices that conform to OSHA regulations, CDC guidelines, accreditation requirements, state and local regulations and currently accepted standards of practice." 5. The agency's September 2013 "Standard Precautions For All Health Care Workers" policy and procedure number B-410 states, "ViaQuest has established Standard Precautions for All Health Care Workers. Employees should assume that blood and all body fluids, with or without visible blood, from all patients are potentially infectious." 6. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of

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Event ID: EDWC

EDWQ11 Facility

Facility ID: IN005940

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	R MEDICARE & MEDI		$(\mathbf{V}\mathbf{a})$ M		NSTRUCTION		OMB NO. 0938	5-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ULTIPLE CO JILDING		(X	(3) DATE SURVEY COMPLETED	
AND FLAIN	of condenion	157223	A. B. B. W		00		05/20/2016	
NAMEOF	PROVIDER OR SUPPLIE			STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
					IIGHWAY 41 NOR	RTH		
VIAQUE	ST HOME HEALT	h of Indiana, LLC		EVANS	VILLE, IN 47725			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN	I OF CORRECTION	(X5	5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	CTION SHOULD BE	COMPLE	ETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	NCY)	DATI	E
	healthcare, avo	id unnecessary touching of						
	surfaces in clos	e proximity to the patient						
	to prevent both	contamination of clean						
	hands from env	ironmental surfaces and						
	transmission of	pathogens from						
		ands to surfaces						
		ygiene: IV.A.3.a. Before						
		ontact with patients.						
	-	r contact with blood, body						
		ions, mucous membranes,						
		or wound dressings.						
		-						
		r contact with a patient's						
		, when taking a pulse or						
	-	or lifting a patient).						
		s will be moving from a						
		ody site to a clean-body						
	• •	ent care. IV.A.3.e. After						
	contact with ina	animate objects (including						
	medical equipn	nent) in the immediate						
	vicinity of the p	patient. IV.A.3.f. After						
	removing glove	esIV.F.5. Include						
	multi-use electr	onic equipment in						
		ocedures for preventing						
		and for cleaning and						
		pecially those items that						
		ients, those used during						
		ent care, and mobile						
		moved in and out of						
		requently IV.B.						
	-	tive equipment (PPE)						
	-							
		s. IV.B.2.a. Wear gloves						
		reasonably anticipated that						
		ood or potentially						
	infectious mate	rials, mucous membranes,						

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

	DICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
NAME OF PROVIDER OR SUPP		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
· · · ·	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS DEEDENCED TO THE ADDRODO	(X5) COMPLETION
TAG REGULATORY	Y OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	n, or potentially l intact skin could			
	E OF PATIENTS, POC, MED			
Based on rece was determine maintain come by failing to determine by failing to determine treatments has accordance we 12 records re- failing to ensist specific to the all treatments (See G 159); for therapy see procedures to reviewed of p services (See ensure staff h- changes in th- condition in 4 (See G 164); verbal orders the registered of 12 records	ord review and interview, it and the agency failed to apliance with this condition ensure ensure services and ad been provided in with physician orders in 5 of viewed (See G 158); by ure plans of care care were e assessment and included in 3 of 12 records reviewed by failing to ensure orders ervices included the specific obe used in 1 of 9 records batients that received therapy e G 161); by failing to ad alerted the physician to e patients' needs and 4 of 12 records reviewed and by failing to ensure had been put into writing by I nurse (RN) or therapist in 2 reviewed (See G 166). ve effect of these systemic	G 0156	The corrective actions, monit plans and responsible parties this Condition are located un G158, G159, G161 and G16 42 CFR 484 18 Acceptance of Patients Plan Care Medical Supervision	s for der 4.

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 FORM APPROVED

 OMB NO. 0938-0391

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

STATEME AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		· /	VILDING NG	00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIEI ST HOME HEALTH			14649 I	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH WILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPR DEFICIENCY)	
		FR 484.18 Acceptance of Care, and Medical				
G 0158 Bldg. 00	SUPER Care follows a wri- established and p doctor of medicine medicine. Based on record the agency failed treatments had b accordance with 2, 3, 5, 11, and 1 reviewed. The findings inc 1. Clinical reco- plan of care esta for the certificat 6-13-16. The pl assessment with [congestive hear management, ed levels, cardiac a and management weight daily and 2 lbs. in one day as per physician	eriodically reviewed by a e, osteopathy, or podiatric review and interview, d to ensure services and been provided in physician orders in 5 (#s 2) of 12 records lude: rd number 2 included a blished by the physician ion period 4-16-16 to an of care states, "Skilled focus on CHF t failure]: medication ema, weight, dyspnea ssessment, oxygen safety t Instruct to record t o report weight gain of or 5 lbs in one week or	G 0	158	All agency clinical staff will b educated on the following: ·Requirements of 484.18 (Acceptance of Patients, Pla Care andMedical Supervision ·Care must follow a written of care established and periodically reviewed by a doctor of medicine, osteopathy, orpodiatric medi ·Services and treatments r be provided in accordance w physician orders ·Agency Policy C-635 (Physician Orders) ·All clinical staff will be educated on individualizing e patient's plan of care based the assessment and needs of patient and that the plan of c must be followed. ·Agency clinical software generated care plans/guideli will be revised to exclude inappropriate auto-populated interventions. A clinical record review of 2 of active patients will be	n of plan cine nust iith each on of the are nes

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				ОМ	IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	î î	ILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLIE	r † of Indiana, LLC		14649 I	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	-	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	 4-28-16, 5-2-16 and 5-16-16, fail had assessed an weight. B. A SN rec dated 4-14-16 s incontinent [urin for the certifican 6-13-16 include the incontinence "Assess instruct management, i.e suggest they we undergarments a Assess/instruct patient, to give reminders durin them to bathroo SN visit r 4-21-16, 4-25-1 5-5-16, 5-9-16, failed to eviden and addressed th The SN visit no urinary status w limits]." C. The plan certification per states, "Hgb A1 	nary]." The plan of care tion period 4-16-16 to ad interventions to address e. The plan states, c on incontinence e. kegals, time-voiding, ear protection in			conducted to determine compliance with the requirem of G158. Clinical Record number 2: A. The physician was notified the SN failed to assess and monitor the patient's weight p the plan of care. Physician or was obtained to discontinue of weights. B.One on one education will provided to the SN who failed assess and address the patie urinary incontinence as it was identified on the assessment included in the plan of care. S will assess and address patie incontinence on every visit. C. SN drew HbA1c prior to initially ordered date, per writt physician order obtained by patient, so results would be available for physician's appointment.SN failed to discontinue the original order the lab to be drawn on 5/19/16and SN failed to place written order in the clinical rec or call to clarify, via verbal ord that the HbA1c was to be dra early. One on one education be provided to this SN and SI obtain written or verbal orders all changes to the plan of care Clinical Record number 3: A.SN failed to document how dressing change was perform Education providedto all clinic staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed.	that er der laily be to nt's and SN nt's en for e the cord der, wn will N will s for e. v the ned. cal	

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	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157223	B. WING		05/20/2016	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R	14649	HIGHWAY 41 NORTH		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC	EVANS	SVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	due 5/19/16."			B.SN failed to document at		
				Hydrogel was applied to wou		
	1) A SN	visit note dated 5-12-16		per physician order.Education		
	· · · ·			provided to all clinical staff, o		
		w ordered labs from [name		5/24/16 and 5/25/16, regardi		
	of physician] vi	a venipuncture." The		appropriate documentation of	it i	
	record failed to include an order for the venipuncture on 5-12-16.			wound care performed. In		
				addition, all clinical staff will educated on the requiremen		
				following physician orders.		
	2) The re	cord failed to evidence		Clinical Record number 5:		
	2.) The record failed to evidence			A.Occupational therapy faile	ed to	
	Ũ	Hgb A1C had been drawn on 5-19-16		complete an evaluation per		
	per the plan of	care.		physician order;physician wi	lbe	
				notified that the Occupationa		
	3.) The record included a "Case			Therapy evaluation was not		
	Communication	n Report" dated 5-9-16		completed. All therapy staff		
		has written order from		be educated regarding follow	-	
		cian] given to patient for		physician orders and approp		
				documentation and physician		
		alc before upcoming appt		notification when changes to	the	
	on 5-19-16." T	he record failed to		plan of care are necessary. B.The Occupational Therap		
	evidence the wr	ritten order.		evaluation was not provided		
				indicated on the Admission		
	2 Clinical reco	ord number 3 included a		Service Agreement and the		
		ers dated 4-25-16 that		physician will be notified that	it	
		SN to change wound care		was not completed. All clinic	al	
	,	e		staff will be educated that		
		el on wounds, then		services must be provided p		
		ver with foam dressing.		physician orders and physici	an	
	Dressing chang	e will remain 3 times per		notification is required when		
	week as previou	usly scheduled."		changes to the plan of care/physician orders are		
	-			necessary. Clinical Record		
	A. SN visit notes, dated 4-27-16 and 4-29-16, failed to evidence how the			number 11:		
				A. SN failed to document h	w	
				the dressing change was	-	
	0 0	e was performed. The		performed. Education provid	ed to	
	notes state, "wo	ound care performed."		all clinical staff, on 5/24/16		
				and5/25/16, regarding		
	B SN vigit	notes, dated 5-13-16 and	1	appropriate documentation of	f	

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Event ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI

	T OF HEALTH AND HU R MEDICARE & MEDI					RM APPROVED IB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED	
	157223				05/20	/2016
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
VIAQUE	/IAQUEST HOME HEALTH OF INDIANA, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	5-16-16, failed	to evidence the SN had		wound care performed.		
	applied the Hyd	lrogel per the physician's		B. SN failed to document that	it	
	order.			the wound care had been	-14-	
				performed. Education provider all clinical staff, on 5/24/16	d to	
	2 Clinical read	ord number 5 included a		and5/25/16, regarding		
				appropriate documentation of		
		Order Request" signed and		wound care performed. In		
	date by the phy	sician on 4-15-16. The		addition, all clinical staff will be	е	
	order states, "T	o evaluate and treat		educated on the requirement	of	
	Physical Therap	py, Occupational		following physician orders.		
	Therapy."			C. SN failed to document wo	und	
	1.2			care appropriately. Education		
	A The room	ord failed to evidence an		provided to all clinical staff, on		
				5/24/16 and 5/25/16, regarding	•	
	-	erapy evaluation had been		appropriate documentation of wound care performed. In		
	completed.			addition, all clinical staff will be	<u>-</u>	
				educated on the requirement		
	B. The reco	rd included an		following physician orders.		
	"Admission Ser	rvice Agreement", signed		Clinical Record number 12:		
		e patient on 4-21-16, that		The SN failed to document, o	n	
	-	cupational therapy		5/6/16, that the patient's legs	had	
	identifies all 00	cupational merapy	1	been wrapped per the physicia	an	

C. The Clinical Director stated, on 5-20-16 at 11:10 AM, "The order was missed."

evaluation would be provided.

4. Clinical record number 11 included a plan of care established by the physician for the certification period 4-26-16 to 6-24-16. The plan of care states, "Wound Care Orders for Right buttocks: Cleanse with ns [normal saline] and pat dry with gauze, apply Prisma to area, cover with foam."

been wrapped per the physician order; however, per this SN she did wrap the patient's legs per physician order but failed to document the procedure. SN instructed to annotate the visit note of 5/6/16 to include this documentation. Patient had seen physician on 5/3/16 and the physician had removed the wraps to patient's legs and failed to reapply them, per documentation in the clinical record. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH			
VIAQUE	ST HOME HEALTH	h of Indiana, LLC	EVANS	SVILLE, IN 47725		
X4) ID PREFIX TAG	(EACH DEFICIE	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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	 failed to evident was performed. care performed well." B. A SN visitor evidence the performed. C. A SN visitor evidence the feature of the set of the s	sit note dated 4-30-16 ice how the wound care . The note states, "wound . pt [patient] tolerated sit note dated 5-2-16 failed wound care had been sit note dated 5-13-16 foal dressing was applied, idence the Prisma was physician's order. ord number 12 included a ablished by the physician tion period 5-2-16 to blan of care states, "Sn to care. Cleanse legs with , pat dry. Apply Aquafor ralent, and wrap legs in 4 essing with 3 layer being in h. Wrap toes with cotton ad then cover with coban."		educated on the requirement following physician orders. of all visit notes will be revier weekly for compliance of providing care in accordance physician orders/plan of care beginning week of 6/13/16 ff period of 6 weeks. Compliant threshold is 90%. If Thresho 90% is achieved for 6 consecutive weeks then char audits will be decreased to 2 quarterly chart reviews. The Clinical Director/design be responsible for monitoring these corrective actions to e that this deficiency is correct	25% wed e with e or a nce old of art 10% ee will g ensure	

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PRINTED: 06/17/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 6. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 7. The agency's August 2013 "Physician Orders" policy and procedure number C-635 states,"All care and service provided will be in accordance with physician orders." G 0159 484.18(a) PLAN OF CARE The plan of care developed in consultation Bldg. 00 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. G 0159 Education will be provided to 06/19/2016 Based on record review and interview, agency clinical staff on the the agency failed to ensure plans of care following: care were specific to the assessment and •The requirements of 484.18 (a) included all treatments in 3 (#s 4, 6, and (Plan of Care) •That the plan of care, 8) of 12 records reviewed. developed in consultation with the agency staff, covers all pertinent The findings include: diagnoses, including mental status, types of services and equipment required, frequency of 1. Clinical record number 4 included a

the patient had no urinary incontinence. FORM CMS-2567(02-99) Previous Versions Obsolete

start of care comprehensive assessment

dated 4-26-16. The assessment identifies

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visits, prognosis, rehabilitation

activities permitted, nutritional

requirements, medications

potential, functional limitations,

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	r I of Indiana, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETIC
	The plan of care physician for th 4-26-16 to 6-24 interventions re of urinary incom- states, "Assess in management, i.e. suggest they we undergarments a caregivers not to frequent cues an activity, accomp- bathroom allow 2. Clinical reco- start of care com- dated 3-31-16. the patient had in The plan of care physician for th 3-31-16 to 5-29 interventions re of urinary incom- states, "Assess in management, i.e. suggest they we undergarments a caregivers not to frequent cues an activity, accomp- bathroom allow 3. Clinical reco-	e, established by the e certification period -16, includes lated to the management attinence. The plan of care instruct on incontinence e. kegals, time-voiding, ear protection in at night assess/instruct to rush patient, to give nd reminders during bany them to the privacy." ard number 6 included a inprehensive assessment The assessment identifies no urinary incontinence. e, established by the e certification period -16, includes lated to the management attinence. The plan of care instruct on incontinence e. kegals, time-voiding, ear protection in at night assess/instruct to rush patient, to give ind reminders during bany them to the		and treatments, any safety measures to protect agains injury, instructions for timely discharge or referral and appropriate items •The plan of care must be specific to the assessment patient's needs •Agency Policy C-580 (Pl Care) •Agency clinical software generated care plans/guide will berevised to exclude inappropriate auto-populate interventions to allow the individualizing of patient-sp interventions. A clinical record review of 2 active patients will be cond to determine compliance w requirements of G159: tha plan of care is based on the patient's comprehensive assessment and contains the required elements. C Record #4: This patient had no urinary incontinence. A physician c will be obtained to correct t plan of care to remove the interventions related to urin incontinence. The agency of software generated interve un-related to the patient's assessment that were erroneously included in the of care. The agency clinica software will be revised to exclude inappropriate, auto-populated interventior allow individualization. Cli Record #6:	et y y other e of the lan of elines ed becific 25% of ucted ith the t the e all of clinical order he hary clinical ntions plan l ns to

Event ID: EDWQ11 Facility ID: IN005940

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PRINTED: 06/17/2016 FORM APPROVED OMD NO 0039 0301

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	00	COMPLETED 05/20/2016
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
AME OF	PROVIDER OR SUPPLIE	R	14649	HIGHWAY 41 NORTH	
/IAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVANS	SVILLE, IN 47725	
K4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	E COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	for the certificat	ion period 4-12-16 to		This patient had no urinary	
	6-10-16. The pl	an of care included		incontinence. A physician or	
	orders for occur	bational therapy visits 2		will be obtained to correct th	e
	-	for 4 weeks. The orders		plan of care to remove the interventions related to urina	n/
	-	onal therapy failed to		incontinence. The agency cli	-
	-			software generated intervent	
	-	ific treatments to be		un-related to the patient's	-
	provided.			assessment that were	
				erroneously included in the p	blan
	4. The Clinical	Director was unable to		of care.The agency clinical	
	provide any add	itional documentation		software will be revised to	
	and/or informati	ion when asked on		exclude inappropriate,	
		PM and on 5-20-16 at		auto-populated interventions allow individualization.	to
	10:35 AM.			Clinical Record #8:	
	10.55 ANI.			A physician order will be obt	ained
				to amend the plan of care to	
		3-28-13 "Plan of Care"		include thespecific Occupation	onal
	policy and proce	edure number C-580		Therapy treatments to be	
	(HH) states, "Th	ne Plan of Care is based		provided. All therapists will b	
	on a comprehen	sive assessment and		educated on the requiremen	
	information pro-			include specific treatments to	
		nd health team members.		provided on all therapy order	
				services. Beginning with pl	
		Care shall be completed in		of care dated 6/13/16 and la 100% of all Plan of Cares wi	
		Specific procedures		audited weekly to ensure that	
	and modalities f	for therapy services		plan of care is specific to the	
	.Medications, tr	eatments, and		assessment and the patient'	
	procedures."			needs. This audit will also er	
	-			that the plans of careinclude	the
				all pertinent diagnoses, inclu	ding
				mental status, types of	
				servicesand equipment requ	
				frequency of visits, prognosis	
				rehabilitation potential, funct limitations, activities permitte	
				nutritional	.u,
				requirements, medications ar	nd
				treatments, any safety meas	
				to protect against injury,	
	1				

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	II TIPLE CO	NSTRUCTION		MB NO. 0938-0391	
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			r í	(X3) DATE SURVEY COMPLETED	
		157223	B. WI		<u></u>		05/20/2016	
NAME OF I	PROVIDER OR SUPPLIE	P		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					HIGHWAY 41 NORTH			
		I OF INDIANA, LLC			VILLE, IN 47725			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE	
					instructions for timely disch or referral and any other appropriate items. This audi continue for a period of 6 w Threshold is 90%. If thresh 90% is met 6 consecutive w in a row, the chart audits ca decreased to a 10% quarte chart audit. The Clinical Director/designee will be responsible for monitoring to corrective actions to ensure this deficiency is corrected.	t will eeks. iold of veeks an rly hese		
Bidg. 00	specific procedur used and the am duration. Based on record the agency faile therapy services procedures to be records reviewe therapy services The findings ind 1. Clinical reco plan of care esta for the certifica 6-10-16. The p orders for occup times per week	clude: ord number 8 included a ablished by the physician tion period 4-12-16 to lan of care included pational therapy visits 2 for 4 weeks. The orders	G 0	161	All agency therapy staff will educated on the following: ·Requirements of 484.18 (Plan of Care) ·Orders for therapy servic must include the specific proceduresand modalities To be used and the amount,frequency and dura treatment ·Agency Policy C-580 (Pl Care) A clinical record review of of active patients will be conducted to determine compliance with the require of G161: that orders for the services must include the s procedures and modalities	(a) ees ation of an of f 25% ements rapy pecific to be	06/19/2010	
	for the occupati	onal therapy failed to ific procedures to be used			procedures and modalities used and the amount, frequ and duration of treatment. Clinical Record #8: The pl	iency		

	R MEDICARE & MEDI					1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2016		
	PROVIDER OR SUPPLIE	I R I OF INDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	1	
(X4) ID PREFIX	SUMMARY	TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETIC
TAG	 The Clinical provide any add and/or informat 19-16 at 2:40 10:35 AM. The agency's policy and proc (HH) states, "Th on a comprehent information pro patient/family a . The Plan of C full to include: 	nd health team members . Care shall be completed in Specific procedures For therapy services	TAG	DEFICIENCY) care did not contain the spec procedures to be used and treatments to be provided to patient. A physician order will obtained to amend the plan of care to include the specific procedures and treatments to provided to the patient. All therapy staff will be educated including the specific proced and treatments on the plan of care for all patients to receive therapy services. Beginning plans of care dated 6/13/16 a later, 100% of all plans of care will be audited weekly to ensist that the orders for therapy services include thespecific procedures and modalities to used and the amount, freque and duration of treatment. Th audit will continue for a perio 6 weeks. Threshold is 90%. I threshold of 90% ismet 6 consecutive weeks in a row, chart audits can decreased to 10% quarterly chart audit. T Clinical Director/designee wi responsible for monitoring th corrective actions to ensure	the I be of o be d on ures f e y with and re ure o be ency his d of f the o a he I be ese	DATE
G 0164 Bldg. 00	Agency profession physician to any need to alter the Based on record	EW OF PLAN OF CARE nal staff promptly alert the changes that suggest a plan of care. I review and interview, d to ensure staff had	G 0164	this deficiency is corrected. All agency professional staff be educated on the following	:	06/19/203
		ician to changes in the and condition in 4 (#s 2,		·Requirements of 484.18 (I (Periodic Review of the Plan Care)		

PRINTED: 06/17/2016

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION O	COMPLETED 05/20/2016		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIC		
TAG		R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE		
	3. 6. and 8) of 1	2 records reviewed.		·Agency professional staff mu	st		
	The findings inc			promptly alert the physician to anychanges that suggest a nee to alter the plan of care ·Agency Policy C-580 (Plan o Care)			
	evidence the reg	gistered nurse (RN) had		·Appropriate use of case			
		ysician of a change in the		communication notes and			
	-	nt's wound and a change		appropriate carecoordination ·Agency clinical			
	-	of the wound drainage.		software-generated care plans/guidelines have been			
	A. A skilled	l nurse (SN)		modified to include appropriate interventions, including			
	recertification v	isit note dated 4-14-16		interventions directed at patients	6		
	evidenced the w	ound was located on the		on whom a weight is not able to			
	left shin and me	asured 0.5 centimeters		be obtained			
	(cm) in length a	nd 0.2 cm in width. The		A clinical record review of 25% of active patients will be)		
	note classified t	he wound as an abrasion		conducted to determine			
	with a scant ame	ount of serous drainage.		compliance with the requirement of G164: that agency profession	nal		
	B. A SN vis	it note dated 4-25-16		staff promptly alert the physicial to any changes that suggest a	n		
	evidenced the w	ound was located on the		need to alter the plan of care.			
	patient's left kne	ee, was 0.5 cm in length		Agency professional staff will al	ert		
	and 0.2 cm in w	idth with a "moderate		the physician to any changes th			
	amount serous p	ourulent (yellow/tan)		suggest a need to alter the plan of care and document the			
	drainage."			physician notification in the			
				clinical record in the visit note o	r		
	C. A SN vis	it note dated 5-5-16		using a case communication			
	evidenced the w	ound was located on the		note. Clinical Record #2 (A-D) The SN documented the			
	left knee and wa	as 3.5 cm in width and 0.5		presence of the wound in the			
	cm in length with a "small" amount of			60-day summary provided to the	e		
	-	w/tan) drainage."		physician; however, the wound measurements were not include The SN failed to document			
	D. On 5-18-	16 at 12:45 PM, during a		evidence of physician notification	n		
		tient number 2, employee		related to changes in the size			
	-	d, "The open area was		andcondition of the patient's			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	R I OF INDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	•
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
PREFIX TAG	REGULATORY OF scabbed. Two w draining yellow physician. [The PCP [primary c 2. Clinical reco plan of care esta for the certifican 5-20-16. The p interventions to failure including states, "Instruct and to report we day or 5 lbs in c physician order A. A SN vis identifies the pa daily due to "me would also be u stand on a scale and living alone B. The reco physician had b patient's inabilit weights to moni signs and sympt failure. 3. Clinical reco plan of care esta for the certifican	A LSC IDENTIFYING INFORMATION) weeks ago it started fluid. I did tell the patient] goes to see the are physician] tomorrow." rd number 3 included a ablished by the physician tion period 3-22-16 to lan evidenced address congestive heart g daily weights. The plan to record weight daily eight gain of 2 lbs in one one week or as per " it note dated 4-6-16 tient is unable to weigh orbid obesity" and "it nsafe for [the patient] to due to morbid obesity	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) wound. No harm came to this patient as a result of the failur the SN to document the requi- physician notification and the physician was notified of the changes in the patient's wour This SN was educated and counseled on the requirement G164: to promptly alert the physician to any changes that suggest a need to alter the pl of care and appropriate documentation of that notificat Clinical Record #3 (A-B) This patient is unable to weig daily but interventions on the of care did include daily weig The SN did identify this but fat to notify the physician of the patient's inability to complete weights. The physician has b notified of the patient's inabilit complete the daily weights ar the plan of care amended to reflect the patient's inability to so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose testing. The SN documented that the patient of not comply with blood glucose testing and did exhibit s/s relat to hypoglycemia. The SN faile document physician notification the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's noncompliance with blood glucose testing. The SN is no longer employed by	daily een ty to nd to no f

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING			SURVEY ETED /2016
	PROVIDER OR SUPPLIE	R H OF INDIANA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	 interventions to control. The pla with focus on ditesting and eval A. SN visit 1 4-8-16, 4-13-16 5-6-16, and 5-11 does not "check and that the patipatient] feels." B. An "Adm dated 3-31-16 s OOB [our of be a blood sugar in compression fraction of the patient's relucta sugar testing. 4. Clinical recomposition of the patient of the patient. 	address blood glucose an states, "SN to perform iabetes: blood glucose uation." notes, dated 4-6-16, 6, 4-18-16, 4-27-16, 3-16 evidenced the patient blood sugar regularly" ient can tell by "how [the nission Note Report" tates, "Patient had fallen d] and was noted to have in the 40's. New netures found." rd failed to evidence the een informed of the nce to perform blood			agency. All nursing staff have been educated regarding the requirement to notify the physician of any changes in patient condition that sugges need to alter the plan ofcare. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no lo being needed and failed to document wound care perfor on the 5/13/16 visit. The wor care was not discontinued ar the patient performed wound on 5/18/16as observed and documented by the SN. The physician has been notified of condition/improvement of the wound. This SN has been educated regarding the requirement of G164: that ag professional staff must prom alert the physician to any cha that suggest a need to alter t plan of care. PT failed to no the physician that PT service were discontinued per patien request. The physician has b	ency otly anges he tify s t	
	for the certificat 6-10-16. The p [caregiver] Pt [t	ablished by the physician tion period 4-12-16 to lan of care states, "SN/CG patient] to cleanse wound prmal saline] and gauze			notified and the therapist educated regarding the requirement of G164: that the physician must promptly be alerted to any changes that suggest a need to alter the p		

using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape."

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of care. 25% of all visit notes

compliance of documentation that

will be reviewed weekly for

the physician was informed

promptly of any changes that suggest a need to alter the plan

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Event ID:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CON	ISTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING <u>00</u> B. WING		00	COMPI 05/20	
			GT	DEET AI	DDRESS, CITY, STATE, ZIP CODE		0.2010
NAME OF	PROVIDER OR SUPPLIE	R			IGHWAY 41 NORTH		
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC			/ILLE, IN 47725		
(X4) ID		STATEMENT OF DEFICIENCIES	ID)			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	E	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)	TA	G	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	A. A SN vis	ait note dated 5-13-16			of care beginning week of 6	/13/16	
	notes "wound h	as covered over with scab			for a period of 6 weeks.		
		ainage notes. Pt advised			Threshold is 90%. If Thresh	old of	
		v still be open some			90% is achieved for 6 consecutive weeks then cha	art	
	underneath and			audits can be decreased to			
		eoura open ouek up.			quarterly chart reviews. Th		
	B The reco	rd failed to evidence the			Clinical Director/designee w		
		een notified of the			responsible for monitoring the		
	condition of the			corrective actions to ensure this deficiency is corrected.	that		
					this denotency is corrected.		
	dressing change	was no longer needed.					
	C. The plan	of care included orders					
	-	rapy (PT) services 2 times					
	per week for 4						
	•	ischarge note dated					
		tes, "D/C [discontinue]					
		per patient request."					
	The reco	d failed to evidence the					
	physician had b	een notified PT services					
		tinued prior to the end of					
	the 4 weeks as						
	5. The Clinical	Director was unable to					
		litional documentation					
		ion when asked on					
		PM and on 5-20-16 at					
	10:35 AM.						
	6. The agency's	s 3-28-13 "Plan of Care"					
		edure number C-580					
		ofessional staff shall					
		he physician to any					
		ggest a need to alter the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Plan of Care." G 0166 484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Bldg. 00 Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on record review and interview, G 0166 All clinical staff will be educating 06/19/2016 on the following: the agency failed to ensure verbal orders ·Requirements of 484.18 (c) had been put into writing by the (Conformance with Physician registered nurse (RN) or therapist in 2 (#s Orders) That verbal orders must be put 8 and 10) of 12 records reviewed. in writing and signed and dated with the date of receipt by the RN The findings include: or qualified therapist responsible for furnishing or supervising the ordered services. 1. Clinical record number 8 included ·Orders taken by an MSW must verbal physician's orders, dated 4-26-16, be reviewed and co-signed by the 5-9-16, and 5-10-16 for medication dose supervising RN changes. The orders evidenced the ·Orders taken by an LPN must licensed practical nurse (LPN), employee be reviewed and co-signed by the supervising RN M, had put the orders into writing and A clinical record review of 25% signed and dated the orders. of physician orders will be conducted to determine 2. Clinical record number 10 included a compliance with the requirements of G166. Clinical Record #8 The verbal physician's order dated 4-6-16 for orders dated 4/26/16, 5/9/16 and medical social services to be provided 2 5/10/16 were reviewed and times per month for 1 month. The order co-signed by the RN responsible evidenced the medical social worker, for supervising the ordered services and these were located employee N, had put the order into in the medical record housed in writing and signed and dated the order. the Forcura system. The agency failed to print the co-signed order 3. The Clinical Director indicated, on for the surveyor. Supporting

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06/17/2016

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		OMB NO. 0938-0391 TE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		A. BUII B. WIN	00	-	1PLETED 20/2016	
	PROVIDER OR SUPPLIE	R H OF INDIANA, LLC		STREET ADDRESS, CITY, STATE, ZIP CC 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES(EACH DEFICIENCY MUST BE PRECEDED BY FULLREGULATORY OR LSC IDENTIFYING INFORMATION)5-20-16 at 10:35 AM, she thought thiswas acceptable practice.			ID PROVIDER'S PLAN OF CORR REFIX (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AP DEFICIENCY) documentation attached Record #10 The Medica Worker accepted and p	DULD BE PROPRIATE d. Clinical al Social ut into	(X5) COMPLETION DATE
				writing a physician orde work services. The MSV educated that verbal ord be put in writing and sig dated by the RN or qual therapist responsible for furnishing or supervising ordered services. All clin we reeducated regardin requirements of G166. Beginning the week of 60 25% of all visit notes wil reviewed weekly, for a p weeks, to ensure that pl orders are reviewed, sig dated by the RN or qual therapist. Compliance th 90%. If Threshold of 90 achieved for 6 consecut then chart audits can be decreased to 10% quar reviews. The Clinical Ma be responsible for moni these corrective actions that this deficiency is co	W was ders must ined and lified r g the nical staff g the 5/13/16, ll be beriod of 6 hysician gned and lified nreshold is 0% is tive weeks e terly chart anager will toring to ensure	
G 0168 Bldg. 00	484.30 SKILLED NURSI	NG SERVICES				
	was determined maintain compl by failing to en- treatments had accordance with 12 records revis	I review and interview, it the agency failed to iance with this condition sure services and been provided in n physician orders in 4 of ewed (See G 170); by e the registered nurse (RN	G 010	58 The corrective actions, plans and responsible p this Condition are locate G170, G173, G176 and 42 CFR 494.30 Skilled Services	ed under G178 .	06/19/201

	R MEDICARE & MEDI						B NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		ì í	ILTIPLE CC	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED		
			B. WI		00	05/20/	
		137223	D. (11		TREET ADDRESS, CITY, STATE, ZIP CODE		2010
NAME OF	PROVIDER OR SUPPLIE	R					
VIAQUE		H OF INDIANA, LLC		EVANS	SVILLE, IN 47725		-
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		,		TAG			DATE
		cessary revisions to the					
	-	4 of 12 records reviewed					
		failing to ensure the					
	-	e (RN)had alerted the					
		anges in the patients'					
		ition in 4 of 12 records					
	· ·	G 176); and by failing to					
		he registered nurse (RN)					
	-	the licensed practical					
		2 of 2 records reviewed of					
	patients that rec	eived services from the					
	LPN (See G 17	8).					
		effect of these systemic					
	-	ed in the agency being					
	found out of co	mpliance with this					
	condition, 42 C	FR 494.30 Skilled					
	Nursing Service	es.					
G 0170	484.30						
Bldg. 00	SKILLED NURS	NG SERVICES es skilled nursing services					
Blug. 00		th the plan of care.					
		d review and interview,	G 01	70	All agency clinical staff will be		06/19/201
		ed to ensure services and			educated on the following: •	_	
	. .	been provided in			Requirements of 484.30 (Skille Nursing Services) • Services a		
		h physician orders in 4 (#s			treatments must be provided in		
) of 12 records reviewed.			accordance with physician orde		
	., _ , _ , _ , , 12	,			Agency Policy C-635 (Physic	ian	
	The findings in	clude.			Orders) A clinical record revie		
					of 25% of active patients will be	9	
	1 Clinical reco	ord number 2 included a			conducted to determine compliance with the requirement	nts	
		ablished by the physician			of G170. Clinical Record		
	-				number 2:		
		tion period 4-16-16 to lan of care states, "Skilled			A.The physician was notified th	at	
	1 0-13-10. The p	an of care states. "Skilled	1		the SN failed to assess and		1

NTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	ł		HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	OF INDIANA, LLC		SVILLE, IN 47725	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	× ×	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	assessment with			monitor the patient's weight	-
	[congestive hear	t failure]: medication		the plan of care. Physician of was obtained to discontinue	
	management, ed	ema, weight, dyspnea		weights.	uany
	levels, cardiac a	ssessment, oxygen safety		B. One on one education wi	ll be
		t Instruct to record		provided to the SN who faile	
	-	to report weight gain of		assess and address the pati	
				urinary incontinence as it wa	
	-	or 5 lbs in one week or		identified on the assessmen	
	as per physician	order.'		included in the plan of care.	
				will assess and address pati	ent's
	A. Skilled nu	urse (SN) visit notes,		incontinence on every visit.	
	dated 4-18-16, 4	-21-16, 4-25-16,		C. SN drew HbA1c prior to initially ordered date, per wri	tton
	4-28-16, 5-2-16,	5-5-16, 5-9-16, 5-12-16,		physician order obtained by	
		led to evidence the SN		patient, so results would be	
		d monitored the patient's		available for physician's	
		i monitored the patient's		appointment.SN failed to	
	weight.			discontinue the original orde	r for
				the lab to be drawn on	
	B. A SN rec	ertification visit note		5/19/16and SN failed to place	
	dated 4-14-16 st	ates, "Patient is		written order in the clinical re	
	incontinent [urir	nary]." The plan of care		or call to clarify, via verbal of	
	-	ion period 4-16-16 to		that the HbA1c was to be dra early. One on one education	
		d interventions to address		be provided to this SN and S	
				obtain written or verbal orde	
		. The plan states,		all changes to the plan of ca	
		on incontinence		Clinical Record number 3:	
	. .	e. kegals, time-voiding,		A. SN failed to document ho	w
	suggest they we	ar protection in		the dressing change was	
	undergarments a	it night		performed. Education provid	
	Assess/instruct of	caregivers not to rush		all clinical staff, on 5/24/16 a	
		requent cues and		5/25/16, regarding appropria documentation of wound car	
		g an activity, accompany		performed. See supporting	
				documentation.	
	inem to bathroom	m (allow privacy)."		B.SN failed to document at	the
				Hydrogel was applied to wou	
	SN visit n	otes, dated 4-18-16,		per physician order.Educatio	
	4-21-16, 4-25-10	6, 4-28-16, 5-2-16,		provided to all clinical staff, o	
	5-5-16, 5-9-16, 5	5-12-16, and 5-16-16,		5/24/16 and 5/25/16, regard	ng

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	OF CORRECTION IDEN	ROVIDER/SUPPLIER/CLIA IIFICATION NUMBER: 223	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIER	NDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	IENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	failed to evidence the and addressed the uri The SN visit notes idu urinary status was "W limits]." C. The plan of can certification period 4- states, "Hgb A1C [blo how well diabetes is 1 due 5/19/16." 1.) A SN visit states, "SN drew orde of physician] via veni record failed to inclue venipuncture on 5-12 2.) The record a the Hgb A1C had bee per the plan of care.	SN had assessed nary incontinence. entifies the patient's /NL [within normal re for the -16-16 to 6-13-16 bod test to assess being controlled] note dated 5-12-16 ered labs from [name ipuncture." The de an order for the -16. failed to evidence en drawn on 5-19-16 included a "Case ort" dated 5-9-16 rritten order from given to patient for efore upcoming appt ord failed to order. mber 3 included a ed 4-25-16 that change wound care		appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will b educated on the requirement following physician orders. Clinical Record number 5: A.Occupational therapy faile complete an evaluation per physician order;physician will notified that the Occupational Therapy evaluation was not completed. All therapy staff w be educated regarding follow physician orders and approprid ocumentation and physician notification when changes tot plan of care are necessary. B.The Occupational Therapy evaluation was not provided a indicated on the Admission Service Agreement and the physician will be notified that was not completed. All clinical staff will be educated that services must be provided pe physician orders and physician notification is required when changes to the plan of care/physician orders are necessary. Clinical Record number 11: A. SN failed to document ho the dressing change was performed. Education provide all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation. B. SN failed to document the the wound care performed. See supporting documentation.	e of d to be vill ing iate he , as it an ww ed to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAR CERVIC

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING	00	05/20/2016
	PROVIDER OR SUPPLIED		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	1
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Aquacel Ag, co	ver with foam dressing.		performed. Education provide	ed to
	Dressing change	e will remain 3 times per		all clinical staff, on 5/24/16	
	week as previou	•		and5/25/16, regarding	<i>c</i>
				appropriate documentation o wound care performed. See	T
	A SN wight	notes dated 4 27 16 and		supporting documentation. Ir	
		notes, dated 4-27-16 and		addition, all clinical staff will b	
		to evidence how the		educated onthe requirement	
		was performed. The		following physician orders. C	. SN
	notes state, "wo	und care performed."		failed to document wound ca	
				appropriately. Education prov	
	B. SN visit r	notes, dated 5-13-16 and		to all clinical staff, on 5/24/16	
	5-16-16, failed t	to evidence the SN had		and5/25/16, regarding appropriate documentation o	f
	applied the Hyd	rogel per the physician's		wound care performed. See	
	order.			supporting documentation. Ir	1
				addition, all clinical staff will b	
	2 Clinical race	rd number 11 included a		educated onthe requirement	of
				following physician orders.	
	·	blished by the physician		Clinical Record number 12:	
		ion period 4-26-16 to		The SN failed to document, of 5/6/16, that the patient's legs	
	-	an of care states, "Wound		been wrapped perthe physic	
		Right buttocks: Cleanse		order; however, per this SN s	
	with ns [normal	saline] and pat dry with		did wrap the patient's legs	
	gauze, apply Pri	sma to area, cover with		perphysician order but failed	to
	foam."			document the procedure. SN	
				instructed to annotate the vis	it
	A A SN vis	it note dated 4-30-16		note of 5/6/16 to include this documentation. Patient had s	seen l
		ce how the wound care		physician on 5/3/16 and the	
				physician had removed the v	raps
	-	The note states, "wound		to patient's legs and failed to	
	-	pt [patient] tolerated		reapply them, per documenta	
	well."			in the clinical record. Educati	
				provided to all clinical staff, o	
	B. A SN vis	it note dated 5-2-16 failed		5/24/16 and 5/25/16, regarding	•
	to evidence the	wound care had been		appropriate documentation o	T
	performed.			wound care performed. See supporting documentation. Ir	
	r			addition, all clinical staff will b	
	C A SNI	it note dated 5-13-16		educated on the requirement	
	$\begin{bmatrix} C. A SIN VIS \end{bmatrix}$	n note dated 3-13-10			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
AND I LAI	of condension	157223	B. WING	00	05/20/2016
	PROVIDER OR SUPPLIE	R R I OF INDIANA, LLC	14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725	I
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLET
	 but failed to evi applied per the p 4. Clinical recorplan of care estates for the certificate 6-30-16. The perform wound soap and water, cream, or equivaling and soap and water, cream, or equivaling figure 8 fashion roll or kerlix and A SN visit mevidence the para wrapped per the note identifies to wrapped upon to the patient had a wraps. 5. The Clinical provide any add and/or informates 5-19-16 at 2:40 10:35 AM. 7. The agency's Orders'' policy a C-635 states,"A 	bal dressing was applied, dence the Prisma was physician's order. ablished by the physician tion period 5-2-16 to lan of care states, "Sn to care. Cleanse legs with pat dry. Apply Aquafor alent, and wrap legs in 4 ssing with 3 layer being in . Wrap toes with cotton d then cover with coban." ote dated 5-6-16 failed to tient's legs had been e physician's order. The he patient was not he SN's arrival and that gone 3 days without Director was unable to litional documentation ion when asked on PM and on 5-20-16 at s August 2013 "Physician and procedure number II care and service e in accordance with		following physician orders. 2 of all visit notes will be review weekly for compliance of providing care in accordance of physician orders/plan ofcare beginning week of 6/13/16 for period of 6 weeks. Compliance threshold is 90%. If Threshold 90% is achieved for 6 consecutive weeks then chart audits will be decreased to 10 quarterly chart reviews. The Clinical Director/designee will responsible for monitoring the corrective actions to ensure th this deficiency is corrected.	ed with a ce d of % be se

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223			ONSTRUCTION <u>00</u>	X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLIE	R I OF INDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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)	(X5) COMPLETION DATE
G 0173 Bldg. 00	The registered nuccare and necessar Based on record the agency faile nurse (RN had if revisions to the 6, and 8) of 12 m The findings ind 1. Clinical record evidence the registering informed the phisize of the patie in the character and initiated a c A. A skilled recertification v evidenced the w left shin and me (cm) in length a note classified t with a scant am B. A SN vis evidenced the w patient's left known and 0.2 cm in w	I review and interview, d to ensure the registered nitiated necessary plan of care in 4 (#s 2, 3, records reviewed. clude: rd number 2 failed to gistered nurse (RN) had ysician of a change in the nt's wound and a change of the wound drainage hange in the plan of care. d nurse (SN) isit note dated 4-14-16 round was located on the asured 0.5 centimeters nd 0.2 cm in width. The he wound as an abrasion ount of serous drainage. it note dated 4-25-16 round was located on the ee, was 0.5 cm in length idth with a "moderate purulent (yellow/tan)	G 0173	All agency professional staff v be educated on the following: Requirements of 484.30 (a) (Duties ofthe Registered Nurs The RN initiates the plan of ca and necessary revisions • Agency Policy C-360 (Coordination ofPatient Care) clinical record review of 25% active patients will be conduc to determine compliance with requirements of G173: that th RN initiates the plan ofcare an necessary revisions. Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to physician; however, the woun measurements were not inclu The SN failed to document evidence of physician notifica related to changes in the size condition of the patient's woul No harm came to this patient result ofthe failure of the SN t document the required physic notification and the physician notified of the changes in the patient's wound. This SN was educated and counseled on th requirements of G164: to promptly alert the physician to any changes that suggest a n to alter the plan of care and appropriate documentation of	 A of ted the d the d <lid< li=""> d d d</lid<>

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	R MEDICARE & MEDIC				OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
NAME OF 1	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COI	DE
				HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVANS	SVILLE, IN 47725	
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				notification. Clinical Red	cord #3
	C. A SN vis	it note dated 5-5-16		(A-B)	
	evidenced the w	yound was located on the		This patient is unable to	-
		as 3.5 cm in width and 0.5		daily but interventions or of care did include daily	
				The SN did identify this b	-
	-	th a "small" amount of		to notify the physician of	
	"purulent (yello	w/tan) drainage."		patient's inability to com	
				weights. The physician h	
	D. On 5-18-	16 at 12:45 PM, during a		notified of the patient's ir	
	home visit to pa	tient number 2, employee		complete the daily weigh	
	-	d, "The open area was		the plan of care amende	
		veeks ago it started		reflect the patient's inabi	
		-		so. Clinical Record #6 (,
		fluid. I did tell the		The plan of care contain	
	physician. [The	patient] goes to see the		interventions to address	
	PCP [primary c	are physician] tomorrow."		glucose control, including	g blood
				glucose testing. The SN	iont doop
	2 Clinical reco	rd number 3 included a		documented that the pat not comply with blood glu	
		blished by the physician		testing and did exhibit s/	
	-			to hypoglycemia. The SN	
		tion period 3-22-16 to		document physician noti	
	5-20-16. The p			the patient's reluctance t	
	interventions to	address congestive heart		perform blood glucose te	esting.
	failure including	g daily weights. The plan		The physician has been	
	states, "Instruct	to record weight daily		of the patient's noncomp	
		eight gain of 2 lbs in one		with blood glucose testin	
	-	one week or as per		SN is no longer employe	
	physician order.	-		agency. All nursing staff been educated regarding	
				requirement to notify the	
				physician of any change	
		it note dated 4-6-16		patient condition that su	
	identifies the pa	tient is unable to weigh		need to alter the plan of	
	daily due to "me	orbid obesity" and "it		Clinical Record #8 (A-C)	
	-	nsafe for [the patient] to		The SN failed to docume	
		due to morbid obesity		physician notification of	
		-		improvement to the patie	
	and living alone	·.		wound and wound care i	-
				being needed and failed	
	B. The record	rd failed to evidence the		document wound care pe	ertormea

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	ONSTRUCTION ()	x3) date survey completed 05/20/2016
	PROVIDER OR SUPPLIEI ST HOME HEALTH		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
VIAQUE (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF physician had be patient's inability weights to moni signs and sympt failure and that to change in the pla patient's inability weights. 3. Clinical recor plan of care esta for the certificat 5-29-16. The pla interventions to control. The pla with focus on di testing and evalu A. SN visit to 4-8-16, 4-13-16, 5-6-16, and 5-13 does not "check and that the pati patient] feels." B. An "Adm dated 3-31-16 st	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) een informed of the y to complete daily tor for fluid retention and oms of congestive heart he RN had initiated a an of care to address the y to complete daily rd number 6 included a blished by the physician ion period 3-31-16 to an of care evidenced address blood glucose n states, "SN to perform abetes: blood glucose			DATE DATE
	physician had be			responsible for monitoring these corrective actions to ensure tha this deficiency is corrected.	e

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG sugar testing and the RN had initiated a change in the plan of care to address the patient's reluctance. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape." A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the physician had been notified of the condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: IN005940 If continuation sheet Page 36 of 104 EDWQ11

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T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONGEDUCTION		
		(A2) MOLTIFLE C	ONSTRUCTION	(X3) DATE S	SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
	157223	B. WING		05/20/	2016
		STREET	ADDRESS, CITY, STATE, ZIP CODE		
KOVIDER OR SUPPLIE	2R	14649	HIGHWAY 41 NORTH		
T HOME HEALTH	H OF INDIANA, LLC	EVAN	SVILLE, IN 47725		
SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETIO
REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
physician had b	been notified PT services				
had been discor	ntinued prior to the end of				
	-				
5 The Clinical	Director was unable to				
	PM and on 5-20-16 at				
10:35 AM.					
(The economi	a Sontombor 2012				
	-				
•					
"The primary c	are Nurse or Therapist				
will assume res	ponsibility for				
updating/chang	ing the Care Plan and				
	-				
	e e				
	• • •				
•	•				
physician to cha	anges in the patient				
condition."					
484.30(a)					
-					
•	atient's condition and				
	d raview and interview	G 0176	All agency clinical staff will be		06/19/20
		001/0		,	00/19/20
)	
changes in the p	patients' needs and				
	THOME HEALTH SUMMARY (EACH DEFICIE REGULATORY O physician had b had been disconthe the 4 weeks as of 5. The Clinical provide any add and/or informat 5-19-16 at 2:40 10:35 AM. 6. The agency's "Coordination of procedure numl "The primary cass updating/chang communication within twenty-fithe conference will be contacted for the change of physician to chass condition." 484.30(a) DUTIES OF THE The registered no progress notes, of informs the physician the agency failed nurse (RN)had changes in the p	ROVIDER OR SUPPLIER THOME HEALTH OF INDIANA, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's September 2013 "Coordination of Patient Care" policy and procedure number C-360 (HH) states, "The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communication changes to caregivers within twenty-four (24) hours following the conference or changes. The physician will be contacted when his/her approval for the change is necessary and to alert physician to changes in the patient condition." 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on record review and interview, the agency failed to ensure the registered nurse (RN)had alerted the physician to changes in the patient's needs and	ROVIDER OR SUPPLIER STREET 14649 EVAN: SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. FREE 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. Free agency's September 2013 6. The agency's September 2013 "Coordination of Patient Care" policy and procedure number C-360 (HH) states, "The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communication changes to caregivers within twenty-four (24) hours following the conference or changes. The physician will be contacted when his/her approval for the change is necessary and to alert physician to changes in the patient condition." 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. G 0176 Based on record review and interview, the agency failed to ensure the registered nurse (RN)had alerted the physician to changes and G 0176	OVIDER ON SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH DEFICENCY MUT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION (EACH DEFICENCY MUT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION (EACH DEFICENCY MUT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION (EACH DEFICENCY ACTION SHOLD SEE (EACH DEFICIENCY ACTION SHOLD SEE (EACH DEFICENCY ACTION SHOLD SEE TO THE APPLORE PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOLD SEE (EACH DEFICIENCY ACTION SHOLD SEE (EACH DEFICIENCY ACTION SHOLD SEE TO THE APPLORE PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOLD SEE TO THE APPLORE PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOLD SEE THE 4 WORKS SPLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOLD SEE THE 4 WORKS SPLAN OF CORRECTION (CONTINICION OF DEFICIENCIES) (CONTINICION OF DATE OF COLL (EACH DEFICIENCY ACTION SHOLD SEE THE APPLICATION WHEN ASKED TO (CONTINICION COLL AND SEE THE POSICIAL MUTIES OF THE REGISTERED NURSE The reguistered nurse prepares clinical and progress notes, coordinates services, informs the physician to other personnel of changes in the patient's condition and needs. Based on record review and interview, the agency failed to ensure the registered nurse (RN)had alerted the physician to changes in the patient's needs and	Control STREET ADDRESS, CITY, STATE, ZIP CODE SOWDER OR SUPPLIER 14649 HIGHWAY 41 NORTH T HOME HEALTH OF INDIANA, LLC 14649 HIGHWAY 41 NORTH EXECUTION OR ISE DESTIFYING INFORMATION ID RECULATORY OR ISE DESTIFYING INFORMATION TAG Physician had been notified PT services Index of the property

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DEFICIENCY) DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG progress notes, coordinates condition in 4 (#s 2, 3, 6, and 8) of 12 services, informs the physician records reviewed. and other personnel of changes in the patient's condition and The findings include: needs. ·The RN must alert the physician to changes in the 1. Clinical record number 2 failed to patient's needs and condition evidence the registered nurse (RN) had Agency Policy C-580 (Plan of informed the physician of a change in the Care) A clinical record review of 25% of size of the patient's wound and a change active patients will be conducted in the character of the wound drainage. to determine compliance with the requirements of G176: that the A. A skilled nurse (SN) RN alerts the physician to changes in the patient's needs recertification visit note dated 4-14-16 and condition Clinical Record #2 evidenced the wound was located on the (A-D) The SN documented the left shin and measured 0.5 centimeters presence of the wound in the (cm) in length and 0.2 cm in width. The 60-day summary provided to the physician; however, the wound note classified the wound as an abrasion measurements were not included. with a scant amount of serous drainage. The SN failed to document evidence of physician notification B. A SN visit note dated 4-25-16 related to changes in the size and evidenced the wound was located on the condition of the patient's wound. No harm came to this patient as a patient's left knee, was 0.5 cm in length result of the failure of the SN to and 0.2 cm in width with a "moderate document the required physician amount serous purulent (yellow/tan) notification and the physician was drainage." notified of the changes in the patient's wound. This SN was educated and counseled on the C. A SN visit note dated 5-5-16 requirements of G164: to evidenced the wound was located on the promptly alert the physician to left knee and was 3.5 cm in width and 0.5 any changes that suggest a need to alter the plan of care and cm in length with a "small" amount of

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D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee

"purulent (yellow/tan) drainage."

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appropriate documentation of that

notification. Clinical Record #3 (A-B) This patient is unable to

weight daily but interventions on the plan of care did include daily

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

VIAQUEST HOME HEALTH OF INDIANA, LLC

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

(X4) ID

PREFIX

TAG

COF HEALTH AND HUMAN SERVICES 2 MEDICARE & MEDICAID SERVICES		RM APPROVED B NO. 0938-0391			
IT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 157223	È Í	LDING	DNSTRUCTION	X3) DATE COMPL 05/20/	ETED
ROVIDER OR SUPPLIER ST HOME HEALTH OF INDIANA, LLC		14649 H	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH WILLE, IN 47725		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K, the RN, stated, "The open area was scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow."			weights. The SN did identify thi but failed to notify the physiciar the patient's inability to comple daily weights. The physician ha been notified of the patient's inability to complete the daily	n of te	

weights and the plan of care amended to reflect the patient's

#6 (A-C) The plan of care contained interventions to

inability to do so. Clinical Record

address blood glucose control,

including blood glucose testing.

The SN documented that the

patient does not comply with

PCP [primary care physician] tomorrow. 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one day or 5 lbs in one week or as per physician order."

A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone."

B. The record failed to evidence the RN had informed the physician of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure.

3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to

blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's non-compliance with blood glucose testing This SN is no longer employed by this agency. All nursing staff have been educated regarding the requirement to notify thephysician of any changes in patient condition that suggest a need to alter the plan of care. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no longer being needed and failed to document wound care performed on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16 as observed and

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documented by the SN. The

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	CONSTRUCTION 00	сомі 05/2	e survey pleted 0/2016
	PROVIDER OR SUPPLIE ST HOME HEALTH	r † of Indiana, LLC	14649	T ADDRESS, CITY, STATE, ZIP CODI 9 HIGHWAY 41 NORTH NSVILLE, IN 47725	E	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OF 5-29-16. The p interventions to control. The play with focus on d testing and eval A. SN visit 4-8-16, 4-13-16 5-6-16, and 5-11 does not "check and that the pati- patient] feels." B. An "Adm dated 3-31-16 s OOB [our of be a blood sugar in- compression fra C. The record RN had informed patient's relucta sugar testing. 4. Clinical record plan of care esta for the certificat 6-10-16. The p [caregiver] Pt [] bed with NS [not using aseptic tea- technique apply	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) lan of care evidenced address blood glucose an states, "SN to perform iabetes: blood glucose uation." notes, dated 4-6-16, 6, 4-18-16, 4-27-16, 3-16 evidenced the patient blood sugar regularly" ient can tell by "how [the hission Note Report" tates, "Patient had fallen d] and was noted to have the 40's. New netures found." rd failed to evidence the ed the physician of the nce to perform blood ord number 8 included a ablished by the physician tion period 4-12-16 to lan of care states, "SN/CG patient] to cleanse wound ormal saline] and gauze chnique. Using aseptic ' Muprocin to wound bed, gauze, wrap with Kerlix	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPR DEFICIENCY) physician has been notified the condition/improvement wound. This SN has been educated regarding the requirement of G164: that professional staff must pro- alert the physician to any that suggest a need to alto plan of care. PT failed to the physician that PTservit were discontinued per path request. The physician has notified and the therapist educated regarding the requirement of G164: that physician must promptly b alerted to any changes that suggest a need to alter th of care. 25% of all visit r will be reviewed weekly, beginning week of 6/13/16 compliance of the RN or of therapist alerting the physic changes in the patient's n and condition, for a period weeks. Threshold is 90%. Threshold of90% is achier 6 consecutive weeks then audits can be decreased to quarterly chart reviews. Clinical Director/designee responsible for monitoring corrective actions to ensu- this deficiency is corrected	2. DBE COPRIATE COPRIATE COPRIATE Company C	(X5) COMPLETION DATE

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the RN had informed the physician of the condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "Professional staff shall promptly alert the physician to any

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EDWQ11 Facility

Facility ID: IN005940 If c

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PRINTED:

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

PRINTED: 06/17/2016 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
	PROVIDER OR SUPPLIE	r i of Indiana, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	changes that sug Plan of Care."	ggest a need to alter the			
G 0178	484.30(a)				
		REGISTERED NURSE			
Bldg. 00	-	Irse participates in			
	teaches other nu	ms, and supervises and			
		I review and interview,	G 0178	All clinical staff will be educated	06/19/2016
		d to ensure the registered		on:	
		supervised the licensed		•The requirements of 484.30(
	· · ·	LPN) in 2 (#s 8 & 10) of		-Duties of the Registered Nurse •The RN participates in	
	-	ved of patients that		in-service programs and	
		es from the LPN.		supervises and teaches other	
				nursing personnel.	
	The findings inc	clude:		•The RN must supervise the LPN	
	888888			A clinical record review of 25%	of
	1. Clinical reco	rd number 8 included		active patients receiving nursing	
		sit notes, signed and dated		services delivered by the LPN v	vill
		t failed to evidence		be conducted to determine compliance with the requirement	nts
		he LPN by the RN.		of G178: that the RN supervises	
				the LPN, that the record reflects	6
	A. A skilled	nurse visit note, signed		communication between the LP	
		e LPN, employee M, on		and the RN. Clinical Record # 1.The record included a verba	
		"INR [blood test used to		physician's order for medication	
		s being treated with blood		changes and lab test that was	
	-	tions] 2.0 via fingerstick		signed/dated by the LPN and	
	-	ent] tolerated well and		reviewed and co-signed by the RN. Supporting documentation	
	× 1 C1	t and results called to		attached.	
		tian] and spoke with		2. The clinical record contains	a
	[name of office			communication note, dated	
		T].		5/10/16, between the LPN and RN,regarding the PT/INR that	
	The record	l included a verbal		demonstrates communication	
		r for medication changes		between the LPN and	
	r=j=termino orde			RN.Supporting documentation	

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	R MEDICARE & MEDI				OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED
		157223	B. WING		05/20/2016
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
VIAQUE	ST HOME HEALT	H OF INDIANA, LLC		HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		DR LSC IDENTIFYING INFORMATION)	TAG	attached.	DATE
		ood test signed and dated		3.The clinical record contain	sa
	by employee M	1 on 4-26-16.		communication note, dated	
				5/17/16, between the LPN and	l l
		l nurse visit note, signed		RN, regarding the PT/INR that	
	-	e LPN, employee M, on		demonstrates communication between the LPN and	
		'PT/INR right middle		RN.Supporting documentation	
	•	[name of physician]."		attached.	
		ed to evidence any		4.The clinical record does	
		between the LPN and the		contain evidence of	~
	RN.			communication, as noted in A- between the LPNand RN	,
				regarding blood test results an	d
	The reco	rd included a verbal		the resulting medication change	jes
	physician's ord	er, signed and dated by		and supporting documentation	is
	employee M or	n 5-9-16 for the fingerstick		attached. 100% of all patient charts the	at
	blood test on 5-	-9-16.		are receiving LPN services wil	
				reviewed weekly,beginning	
	C. A skilled	l nurse visit note, signed		6/13/16, to ensure that the RN	
	and dated by th	e LPN, employee M, on		supervising the LPN appropria	tely
	5-16-16, states,	, "PT/INR right middle		as required, for a period of 6 weeks. Threshold is 95%. If	
	finger results ca	alled to [name of		Threshold of 95% is achieved	
	physician]." The	he record failed to		consistently for 6 weeks then	
	evidence any c	ommunication between the		chart audits can be decreased	
	LPN and the R	N.		to10% quarterly chart reviews The Clinical Director/designee	
				be responsible for monitoring	
	The reco	rd included a verbal		these corrective actions to ens	
	physician's orde	er, signed and dated by		that this deficiency is corrected	d.
	employee M or	n 5-10-16, for a medication			
	change and fur	ther blood testing.			
	D. The reco	ord failed to evidence any			
		between the RN and the			
	LPN regarding	the blood test results and			
		edication changes.			
		č			

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STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	ULTIPLE CON JILDING NG	STRUCTION 00	(X3) DA COM	DMB NO. 0938-03 TE SURVEY 1PLETED 20/2016
	PROVIDER OR SUPPLIEF		14649 HI	DRESS, CITY, STATE, ZIP C GHWAY 41 NORTH ILLE, IN 47725	ODE	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC
TAG	 Clinical recorsistilled nurse visis by the LPN, emp The note states, [spouse] about p specimen for UA speak with RN at explained the got to not only educt we can prevent at [spouse] verbalities stubbornly agreed back to hospital A. The record RN had consulted regarding the poly urine specimen. evidence any urites and the got documented." The RN, explained the got documented." The Clinical provide any add and/or informati 5-19-16 at 2:40 and the got specific stuber of the got document specimen. The agency's "Supervision" point of the got specific study and the got document specific study at the got document specific study and the got document specific study and the got document specific study at the got document specific study at the got document specific study and the got document specific study at the got document specific st	ssibility of obtaining a The record failed to	TAG			DATE

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PRINTED: 06/17/2016 FORM APPROVED OMB NO. 0938-0391

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

AND PLAN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	^R I OF INDIANA, LLC	14649	HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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)	(X5) COMPLETION DATE
G 0202	provide License under the direct Registered Prof	ion. ViaQuest shall ed Practical Nurse services ion and supervision of a ressional Nurse when icated and ordered by the			
Bldg. 00	Based on record was determined maintain compl by failing to ensi- evaluation addr subject areas in files reviewed (ensure the com addressed all of and had been ev- of the aide's per with a patient in files reviewed (to ensure writted prepared for the 6 records review G 224).	AIDE SERVICES If review and interview, it the agency failed to iance with this condition sure the competency essed all of the required 1 of 2 home health aide See G 213); by failing to petency evaluation The required subject areas valuated after performance formance of the tasks in 1 of 2 home health aide See G 218); and by failing en instructions had been the home health aide in 1 of wed of patients that health aide services (See	G 0202	The corrective actions, monitor plans and responsible parties this Condition are located unor G213, G218, and G224. 42 CFR 484.36 Home Health Aide Services	for
	problems result inability to main	effect of these systemic ed in the agency's ntain compliance with this FR 484.36 Home Health			

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157223	B. WING	<u></u>	05/20/2016	
			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		HIGHWAY 41 NORTH		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC		SVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5))
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLET	ΓΙΟΝ
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	<u>i</u>
G 0213	484.36(b)(2)(i) COMPETENCY	EVALUATION &				
Bldg. 00	IN-SERVICE TR					
	each of the subje	evaluation must address ects listed in paragraphs (a)				
	(1)(ii) through (xi		G 0213	Agency staff will be educated	on 06/19/2	2014
	the agency faile	d review and interview,	0.0213	the following:	00/19/2	2010
		aluation addressed all of		•The requirements of 484.3		
		bject areas in 1 (file I) of 2		(2)(i)-The competency evaluation	tion	
	-	le files reviewed.		must address each of the subjects listed in paragraphs	(a)	
	nome nearm arc	ie mes leviewed.		(1)(ii) through (xiii)	(a)	
	The findings in	- 1 d		Review of the specific requ	ired	
	The findings in	ciude.		content of the home health ai	de	
	1 Dersonnal El	le I evidenced the		competency evaluation •Agency Policy C-220 (Aide		
		been hired on 2-24-16 to		Services)		
		ealth aide services on		A review of the personnel		
	-			record of all home health aide		
		ency. The file identified a		employed by this agency will conducted to ensure compliant		
	1 5	aluation had been		with G213: that the home hea		
	1	aide on 3-3-16. The		aide competency evaluation		
	1 5	aluation failed to address $(484.26(a)(1))$		addresses all subject matter		
		shower bath $(484.36(a)(1)$		required. Any areas of		
		ansfer techniques		noncompliance identified will result in a reassessment of th	e	
	(484.36(a)(1)(x			home health aide's competen		
		4.36(a)(1)(ix)(F), and		by an outside agency. In		
		ording temperature, pulse,		personnel file I, the home hea		
	and respiration	(484.36(a)(1)(iii).		aide was hired on 2/24/16 and competency was evaluated o		
				3/3/16 and 3/4/16 using the	.1	
		Director indicated, on		incorrect form. The informatio	n	
		PM, the competency		was placed on the correct for	m,	
	-	ided to employee I did not		provided by the Indiana		
	address all of th	ne required subject areas.		Association for Home and Hospice Care, that contains a		

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	00	COMPLETED 05/20/2016
		101220	STREET	ADDRESS, CITY, STATE, ZIP CODE	00/20/2010
NAME OF	PROVIDER OR SUPPLIE	R		HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC	EVAN	SVILLE, IN 47725	
(X4) ID	SUMMARY	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 DEFICIENCY)	ATE COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	the subjects required by G213	DITTE
	Services" polic C-220 (C) state providing aide	s August 2013 "Aide y and procedure number s, "All individuals services will be qualified g and/or competency		However, the incorrect form we left in the personnel file, along with an additional competence assessment performed to me the requirements of the Home Health Aide Registry. Therefore there appeared to be discrepancies related to the competency evaluation. Goin forward, the agency will only utilize the IAHHC aide competency evaluation to evaluate competency of home health aides (once the 2 year preclusion is lifted). 100% on newly hired home health aide personnel files will be audited ensure that the home health a competency evaluation addresses all of the required subject areas. Compliance threshold is 100%. The Clinic Director/designee will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected.	g y et e ore, ng e of to aide cal
G 0218 Bldg. 00	(iii), (ix), (x), and evaluated after o performance of the other subject are this section may written examination after observation a patient.	AI s listed at paragraphs (a)(1) (xi) of this section must be bservation of the aides ne tasks with a patient. The as in paragraph (a)(1) of be evaluated through on, oral examination, or of a home health aide with d review and interview,	G 0218	Agency staff will be educated the following:	on 06/19/20

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CO A. BUILDING B. WING	00500000000000000000000000000000000000	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	er H of Indiana, LLC	14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	competency eva	aluation addressed all of		•The requirements of 484.3	
	the required sub	pject areas and had been		(2)(i)-The competency evaluation	ation
	evaluated after	performance of the aide's		must address each of the	(0)
		the tasks with a patient in		subjects listed in paragraphs (1)(ii) through (xiii)	(a)
	-	ome health aide files		·Review of the specific requ	uired
	reviewed.	she health and thes		content of the home health ai	
	The findings in	clude:		competency evaluation ·Agency Policy C-220 (Aide Services) A review of the personnel rec	•
		le I evidenced the		of all home health aides employed by this agency will	
		been hired on 2-24-16 to		conducted to ensure complia	nce
	-	ealth aide services on		with G213: that the home heat	alth
	behalf of the ag	ency. The file identified a		aide competency evaluation	
	competency eva	aluation had been		addresses all subject matter	
	provided to the	aide on 3-3-16. The		required. Any areas of noncompliance identified will	
	competency eva	aluation failed to address		result in a reassessment of th	ne
		shower bath (484.36(a)(1)		home health aide's competer	-
		ansfer techniques		by an outside agency. In	
)), toileting and		personnel file I, the home hea	
				aide was hired on 2/24/16 an	÷
		4.36(a)(1)(ix)(F), and		competency was evaluated o	n
	e	ording temperature, pulse,		3/3/16 and 3/4/16 using the incorrect form. The informatic	n an
	and respiration	(484.36(a)(1)(iii).		was placed on the correct for	
				provided by the Indiana	,
	2. The Clinical	Director indicated, on		Association for Home and	
	5-20-16 at 4:00	PM, the competency		Hospice Care, that contains a	
	evaluation prov	rided to employee I did not		the subjects required by G21	
	-	ne required subject areas.		However, the incorrect form v	
				left in the personnel file, along	-
	3 The agency	s August 2013 "Aide		with an additional competence assessment performed to me	-
				the requirements of the Home	
		y and procedure number		Health Aide Registry. Therefo	
	. ,	s, "All individuals		there appeared to be	
		services will be qualified		discrepancies related to the	
	-	g and/or competency		competency evaluation. Goi	ng
	evaluations."			forward, the agency will only	

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVAN	SVILLE, IN 47725	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
				utilize the IAHHC aide competency evaluation to evaluate competency of home health aides (once the 2 year preclusion is lifted). 100% of newly hired home health aide personnel files will be audited to ensure that the home health aid competency evaluation addresses all of the required subject areas, including those required to be evaluated after performance of the aide's performance of tasks with a patient . Compliance threshold 100%. The Clinical Director/designee will be responsible for monitoring thes corrective actions to ensure that this deficiency is corrected.	to de is
G 0224 Bldg. 00	HEALTH AIDE Written patient ca home health aide registered nurse professional who supervision of the paragraph (d) of Based on record the agency faile instructions had home health aide reviewed of pat health aide serv	l review and interview, d to ensure written been prepared for the le in 1 (#6) of 6 records ients that received home ices.	G 0224	All clinical staff will be educate on the following: •The requirements of 484.36 (1)-Assignment and Duties of t HomeHealth Aide •Written patient care instructions for the home healt aide must beprepared by the F or other appropriate profession who is responsible for thesupervision of the home heal aide.	(c) he N N nal

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

X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

157223

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

			FORM APPROVED
			OMB NO. 0938-0391
]	(X2) MI	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
	A. BU	ILDING 00	COMPLETED
	B. WI	NG	05/20/2016
		STREET ADDRESS, CITY, STATE, ZIP CODE	
		14649 HIGHWAY 41 NORTH	

VIAQUE	ST HOME HEALTH OF INDIANA, LLC		HIGHWAY 41 NORTH SVILLE, IN 47725	
(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
	 plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care included orders for home health aide services 1 time per week for 8 weeks. The record evidenced the home health aide services had been provided 1 time per week. The record failed to evidence the registered nurse (RN) had prepared written instructions for the home health aide services to be provided. 2. Employee L, the software support person, stated, on 5-19-16 at 2:35 PM, "There is no aide assignment sheet per the RN in the computer." 3. The agency's August 2013 "Aide Care Plan" policy and procedure number C-751 (C) states, "A complete and appropriate Care Plan, identifying duties to be performed by the Aide, shall be developed by a Registered Nurse or Therapist." 		Agency Policy C-751 (Aide Care Plan) A clinical record review of 25% active clinical records of patients receiving home health aide services will be reviewed to ensure that written patient care instructions for the home health aide are present as required by G224. Clinical Record #6 The RN did fail to prepare written instructions for the home health aide services to be provided. Written instructions for the home health aide have now been prepared and are present in the clinical record. This RN is no longer employed with this agency. 100% of all patient charts that are receiving aide services will be reviewed every two weeks, beginning week of 6/13/16, for compliance that each patient record shows evidence of written patient care instructions for the home health aide are prepared by the RN, for a period of 2 months. Threshold is 90%. If Threshold of 90% is achieved consistently for 2 months then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0250 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of			

	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING <u>00</u> B. WING			COMPLETED 05/20/2016	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
VIAQUE	EST HOME HEALTH	H OF INDIANA, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	determine wheth followed in furnis under arrangeme						
		d review and interview,	G 02	50	All clinical staff will be educate	ed	06/19/2016
		ed to ensure health			on the following: •The requirements of 484.52	2(b)	
	·	epresenting the scope of			-Clinical Record Review	-(~)	
	the program ha	d participated in the			·At least quarterly, appropria	ate	
	quarterly clinic	al record review in 4 (2nd			health professionals, represer		
	2015, 3rd 2015	, 4th 2015, and 1st 2016)			at least the scope of the progr		
	of 4 quarters re	viewed.			review a sample of both active and closed clinical records to	3	
	The findings in	clude:			determine whether establisher policies are followed infurnish services directly or under		
	1. The agency'	s clinical record review			arrangement. ·Agency Policy B-260 (QAP	n	
	documentation	for the 2nd, 3rd, and 4th			·Agency Policy B-220 (Clinic	-	
	quarter of 2015	and the 1st quarter of			Record Review)		
	2016 failed to e	evidence a physical			Quarterly clinical record revi		
		bational therapist, medical			will be conducted by appropriate health professionals, represer		
	social worker, o	or speech language			at least the scope of the progr	-	
		participated in the record			on both active and closed clin		
	review.	1 1			records beginning with Quarter		
					2016 record reviews by 6/19/1	16	
	2. The quality	assurance registered nurse,			and moving forward. The Quality Improvement and		
		ited per telephone			Performance Review (QAPI)		
	1 5 ,	-20-16 at 3:05 PM.			committee will monitor ongoin	g	
		and I are the only ones			compliance with G250, on a		
		record reviews. We do			quarterly basis, by ensuring the	nat	
		erapists or anyone else			the appropriate health professionals, representing th	e	
	that does it."	erapists of anyone else			scope of the program, review	~	
					clinical records at least quarte	•	
	2 The educities	tratar indicated and			This will be monitored by addi	-	
		trator indicated, on			this item to the QAPI committee		
		PM the agency had			meeting agenda. The Clinica Director/designee will be	ll	
		cal therapy, occupational			responsible for monitoring the	se	
	therapy, speech	therapy, and/or medical				-	

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

Event ID:

EDWQ11 Facility ID: IN005940

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	00	COMPLETED 05/20/2016
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVANS	SVILLE, IN 47725	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		o patients during the 2nd, arters of 2015 and the 1st		corrective actions to ensure this deficiency is corrected.	hat
	Review" policy least quarterly t ensure, appropr representing at	a September 2013 "Record and procedure states, "At the Clinical Director will iate Health professionals, east the scope of the a sample of both active closed charts."			
0000 Ildg. 00					
lag. 00		e home health re-licensure nvestigation survey.	N 0000	Please see Plan of Correction beginning with tag# N456.	1
	complaint are ci 17-12-1(m), 410 IAC 17-13-1(a)	eficiencies related to the ted at 410 IAC) IAC 17-13-1(a), 410 (2), 410 IAC 17-14-1(a), 1(a)(1)(C), & 410 IAC			
	Survey Dates: 3 and 5-20-16.	5-17-16, 5-18-6, 5-19-16,			
	Facility #: 0059	940			
	Medicare Provi	der # 15-7223			

State Form

Event ID: EDWQ11 Facility ID: IN005940

If continuation sheet Page 52 of 104

	T OF HEALTH AND HU R MEDICARE & MEDI				FORM APPROVED OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
VIAQUE (X4) ID PREFIX TAG N 0456 Bldg. 00	SUMMARY (EACH DEFICIE REGULATORY O Medicaid Vend 410 IAC 17-12-10 Home health age administration/ma Rule 12 Sec. 1(e be responsible for assurance progra following: (1) Objectively a and evaluate the	(e) ency anagement) The administrator shall or an ongoing quality am designed to do the nd systematically monitor quality and	EVANS ID PREFIX TAG	SVILLE, IN 47725 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE
	the administrate agency's quality performance in included quarte by health profes scope of the pro 2015, 4th 2015, quarters review The findings in 1. The agency's documentation quarter of 2015 2016 failed to e therapist, occup social worker, o	tified problems. ent care. d review and interview, or failed to ensure the v assessment and aprovement program rly clinical record review ssionals representing the ogram in 4 (2nd 2015, 3rd and 1st 2016) of 4 ed.	N 0456	All clinical staff will be educate on the following: •The requirements of 410 IA 17-12-1 (e) Home Health ager administration/management •At least quarterly, appropria health professionals, represent at least the scope of the prograve review a sample of both active and closedclinical records to determine whether established policies are followed infurnishing services directly or under arrangement. •Agency Policy B-260 (QAPI •Agency Policy B-220 (Clinical Record Review) Quarterly clinical record review will be conducted by appropriation health professionals, represent at least the scope of the prograve on both active and closed clinical records beginning with Quarter 2016 record reviews by 6/19/1 and moving forward. The Quarter Improvement and Performance	C C ncy ate ting am, c d ng l) cal ews ate ting am, c d ng l) cal ews ate ting am, c d ng l) cal ews ate am, cal am, cal cal cal cal cal cal cal cal

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 53 of 104

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		COM	(X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF	PROVIDER OR SUPPLIE	R	STREI 1464	ODE			
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVA	NSVILLE, IN 47725			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
	 employee P, statistic employee P, statistic employee Q] that do clinical not have any that does it." 3. The administic for the statistic employee of the statistic employee o	s September 2013 "Record and procedure states, "At he Clinical Director will iate Health professionals, least the scope of the a sample of both active		Review (QAPI) commit monitor ongoing compl N456, on a quarterly ba ensuring that the appro- health professionals, re the scope of the progra clinical records at least This will be monitored I this item to the QAPI or meeting agenda The Director/designee will b responsible for monitor corrective actions to en this deficiency is correct	iance with asis, by opriate epresenting am, review quarterly. by adding committee Clinical be ing these asure that		
N 0458 Bldg. 00	employees shall policies. All emp Indiana shall be s	ncy					

	MEDICARE & MEDIC		(V2) 19			X3) DATE	B NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	î î	ILTIPLE CO		COMPL	
	of conduction	157223	B. WI		<u>00</u>	05/20/	
NAME OF PI	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
VIAQUES	T HOME HEALTH	I OF INDIANA, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
0462	health services sl shall include docu the job, including (1) Receipt of jo (2) Qualification: (3) A copy of lim pursuant to IC 16 (4) A copy of cu or registration. (5) Annual perfor Based on record the agency faile included a copy history from the repository in 1 (files reviewed. The findings ind 1. Personnel C had been hired of physical therapy behalf of the age evidence a copy limited criminal State Police rep 2. The Clinical 5-20-16 at 2:30 not include a co	b description. s. ited criminal history -27-2. rrent license, certification, mance evaluations. review and interview, d to ensure personnel files of limited criminal Indiana State Police file C) of 10 personnel elude: evidenced the individual on 5-16-16 to provide v services to patients on ency. The file failed to of the individual's history from the Indiana ository. Director indicated, on PM, personnel file C did py of the individual's history from the Indiana ository as required. h)	N 04	158	Agency staff will be educated of the requirements of 410 IAC 17-12-1(f) The agency will conduct a 100% review of all personnel files to ensure that each employee has had a limite criminal history from the Indiana State Police repository conducted. Annual audits of personnel files will be conducte to ensure ongoing compliance with N458, with a compliance threshold of 100%. All new employees hired will have the appropriate criminal history conducted. The Human Resource Director/designee wil be responsible for monitoring these corrective actions to ensu- that this deficiency is corrected	ed a d I	06/19/201
ldg. 00	administration/ma						

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Event ID: EDWQ11 Facility ID: IN005940

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STATEMF	INT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CO	DNSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		00	COMPL	
		157223	B. WING			05/20/2016	
			STI	REET /	ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIE				HIGHWAY 41 NORTH		
		H OF INDIANA, LLC			SVILLE, IN 47725		
X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	ТА		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110) Each employee who will					DITL
		nt contact shall have a					
		ation by a physician or nurse					
		ore than one hundred					
		s before the date that the					
		rect patient contact. The					
		ation shall be of sufficient that the employee will not					
		or communicable diseases					
	to patients.						
		d review and interview,	N 0462		Agency staff will be educated	on	06/19/201
		ed to ensure personnel files			the requirements of 410 IAC		
		cal examinations in 1 (file			17-12-1(h) The agency will conduct a 100% review of all		
					personnel files to ensure that		
	F) of 10 personnel files reviewed.				each employee has had a		
	The findings in	clude			physical examination by a		
	The mungs m	ciude.			physician or nurse practitioner		
	1 Dersonnel fil	le F evidenced the			nomore than 180 days before		
					date that the employee has dir patient contact. The physical	ect	
		been hired on 5-16-16 to			examination shall be of sufficient	ent	
		tional therapy services to			scope to ensure that the		
	^	alf of the agency. The file			employee will not spread		
		ice a pre-employment			infectious or communicable		
	physical examination	nation.			diseases to patients. All new		
					employees hired will have a physical examination by a		
	2. The Clinical	Director indicated on			physician or nurse practitioner	no	
	5-20-16 at 2:30	PM, personnel file F did			more than 180 days before the		
	not include a co	ppy of the individual's			date that the employee has dir		
	physical examin				patient contact. The physical		
					examination shall be of sufficient	ent	
	3. The agency's	s June 2013 "Health			scope to ensure that the employee will not spread		
		icy and procedure number			infectious or communicable		
		Pre-employment physical			diseases to patients. 100% of	of	
					new hire personnel files will be		
		Il be performed by a			audited to ensure that employed	ees	
		rse practitioner as			hired have had the required		
		ate law or ViaQuest			physical examination no more than 180 days before the date		
	policy.				and in too days before the date		

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PRINTED: 06/17/2016 FORM APPROVED

	R MEDICARE & MEDI					OMB NO. 0938-0391	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT A. BUILD	TPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILL B. WING	00	-	20/2016	
		157223			-	20/2016	
NAME OF I	PROVIDER OR SUPPLIE	2R		TREET ADDRESS, CITY, STATE, ZIP CO	DE		
				4649 HIGHWAY 41 NORTH			
VIAQUE		H OF INDIANA, LLC		EVANSVILLE, IN 47725			
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			D PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	COMPLETION DATE	
TAG	REGULATORY O	K LSC IDENTIFTING INFORMATION)	1.	that the employee has of		DATE	
				patient contact. Complia			
				threshold is 100%. Ann			
				of personnel files will be			
				conducted to ensure on			
				compliance with acomp threshold of 100%. The			
				Resource Director/desig			
				be responsible for moni			
				these corrective actions			
				that this deficiency is co	rrected.		
N 0470	410 IAC 17-12-1	(m)					
	Home health age	. ,					
Bldg. 00	administration/ma	-					
		n) Policies and procedures					
		nd implemented for the inicable disease in					
		applicable federal and state					
	laws.						
	Based on obser	vation, interview, and	N 0470		•	06/19/201	
	record review,	the agency failed to ensure		Employees G, K, and B educated on thefollowin			
	staff had provid	led care in accordance		·Agency Policy B-400	•		
	with the agency	's own infection control		Prevention and Control			
	policies and pro	ocedures and with the		supporting documentati			
	Centers for Dis	ease Control (CDC)		·Agency Policy B-410			
	guidelines in 3	(#s 1, 2, & 3) of 6 home		Precautions for All Heal CareWorkers)-see supp			
	visit observatio			documentation	orung		
				·Centers for Disease	Control's		
	The findings in	clude:		(CDC) Guidelines relate			
	L C			Infection Control and St	andard		
	1. Employee G	, a registered nurse (RN),		Precautions • The requirements of	410 IAC		
		complete an assessment		17-12-1(m) – Home hea			
		ange on patient number 1		agency			
	-	0:00 AM (observation #		administration/manager			
		s observed to remove the		policies and procedures			
	,	ing a pair of bandage		written and implemente			
	•	N removed her gloves		in compliance with fede		1	

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

CENTERS FOR MEDICARE & MEDICAID SERVICES						ОМ	B NO. 0938-0391			
	NT OF DEFICIENCIES NOF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MUI A. BUI B. WIN	LDING	DNSTRUCTION 00	(X3) DATE COMPL 05/20 /	ETED			
	PROVIDER OR SUPPLIE	r † of Indiana, LLC		14649 H	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH WILLE, IN 47725					
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY OF and cleansed he	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) cleansed her hands. The RN cleaned scissors used to remove the old		MUST BE PRECEDED BY FULL PREFIX PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OPENDING ands. The RN cleaned state laws.						
	dressing and do cleansing her ha 2. Employee K complete dressi number 2 on 5- (observation nu cleansed her ha gloves. The RN from the patient her gloves and o then removed th lower leg. The and changed he cleansed the rig lower leg. The	nned clean gloves without			care in accordance with the agency's infection control poli and procedures and with the guidelines, which will be revie and distributed to all clinical s Infection control competency all clinical staff will be re-assessed to ensure compliance with agency polic and procedures and CDC guidelines related to infection control and standard precauti by 6/19/16. Monthly in-servic will be developed, and preser to all clinical staff, related to infection control, standard precautions, and related topic Documentation will be mainta of content and attendance. Home visits to observe wound care performed by RNs will be initiated on a quarterly basis, beginning with quarter 3 of 20 for the remainder of the year,	CDC wed taff. y of ies ons ces nted ss. ined d e				
	clean supplies m changes to the b The RN was ob supplies on a ru barrier. B. After cle extremities, the and changed he measured the le applied a clean	The RN was observed to obtain supplies needed for the dressing es to the bilateral lower extremities. N was observed to place the clean es on a rug on the floor without a After cleansing the lower nities, the RN cleansed her hands anged her gloves. The RN red the left lower leg wound and d a clean Telfa dressing. The RN ed her hands and changed her			order to audit/review appropri technique, staff competency a compliance with infection com policies and procedures. They home visit audits will be documented on a focused au tool. Noncompliance will be addressed with clinicians on a one-to-one basis until 100% compliant. Home visits will the continue annually to ensure continued compliance. The Clinical Director/designee will responsible for monitoring the corrective actions to ensure th this deficiency is corrected.	ate and trol se dit dit en be ese				

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PRINTED: 06/17/2016

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG gloves and applied a a Kerlix wrap and Coban wrap to the left lower leg. The RN then applied a Kerlix wrap to the right lower leg without cleansing her hands or changing her gloves. C. The Clinical Director indicated, on 5-18-16 at 12:50 PM, employee K had not performed the dressing change in accordance with facility policy. 3. Employee B, an RN, was observed to perform a dressing change on patient number 3 on 5-18-16 at 2:40 PM (observation # 3). The RN was observed to cleanse her hands and obtain the needed supplies from the patient's dresser. The RN donned clean gloves without cleansing her hands. A. The RN was observed to apply a gel to two dressings with a gloved finger and then apply the dressings to the wounds on the patient's buttocks. B. The Clinical Director indicated, on 5-18-16 at 3:05 PM, employee B had not performed the dressing change in accordance with facility policy. 4. The agency's June 2013 "Infection Prevention & Control Plan" policy and procedure number B-400 (C) states, "ViaQuest has developed, and

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet

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PRINTED:

06/17/2016

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CONST A. BUILDING B. WING		ISTRUCTION	CC	(X3) DATE SURVEY COMPLETED 05/20/2016		
	NAME OF PROVIDER OR SUPPLIER VIAQUEST HOME HEALTH OF INDIANA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725					
	-								
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
	 implemented in that conform to guidelines, accepted standard 5. The agency' "Standard Preca Care Workers" number B-410 established Standard Preca Workers assume that blow with or without patients are pot 6. The Centers "Standard Preca Hygiene. IV.A healthcare, avo surfaces in closs to prevent both hands from env transmission of contaminated h Perform hand having direct contaminated heaving di	affection control practices OSHA regulations, CDC reditation requirements, regulations and currently ards of practice." s September 2013 autions For All Health policy and procedure states, "ViaQuest has ndard Precautions for All orkers. Employees should ood and all body fluids, e visible blood, from all entially infectious." for Disease Control cautions" states, "IV. utions IV.A. Hand .1. During the delivery of id unnecessary touching of e proximity to the patient contamination of clean irronmental surfaces and pathogens from ands to surfaces ands to surfaces							
	nonintact skin, IV.A.3.c. After intact skin (e.g.	or wound dressings. r contact with a patient's , when taking a pulse or or lifting a patient).							

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	î î	MULTIPLE CC BUILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		157223	B. WING		<u></u>	05/20/2016		
NAME OF	PROVIDER OR SUPPLIE	ER	-		ADDRESS, CITY, STATE, ZIP	CODE		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC			HIGHWAY 41 NORTH WILLE, IN 47725			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
into		s will be moving from a		into			Diffe	
		ody site to a clean-body						
		ent care. IV.A.3.e. After						
		animate objects (including						
		nent) in the immediate						
		batient. IV.A.3.f. After						
		es IV.F.5. Include						
	00	onic equipment in						
		ocedures for preventing						
		and for cleaning and						
		pecially those items that						
		ients, those used during						
		-						
		ent care, and mobile moved in and out of						
	-	requently IV.B. tive equipment (PPE)						
	-	5. IV.B.2.a. Wear gloves						
		-						
		reasonably anticipated that						
		bod or potentially						
		rials, mucous membranes,						
	nonintact skin,							
	occur."	ntact skin could						
	occur.							
N 0472	410 IAC 17-12-2							
		nance improvement						
Bldg. 00) The home health agency plement, maintain, and						
		y assessment and						
	performance imp	rovement program. The						
		flect the complexity of the						
		anization and services services provided directly or						
		ent). The home health						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2016			
NAME OF PROVIDER OR SUPPLIER VIAQUEST HOME HEALTH OF INDIANA, LLC		14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725			
X4) ID PREFIX TAG	(EACH DEFICIE	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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	 improvements in performance across The home health assessment and program must us Based on records the agency failed quality assessment improvement proclinical record of professionals records the program in 44th 2015, and 1 reviewed. The findings in 1. The agency's documentation quarter of 2015 2016 failed to e therapist, occup social worker, or pathologist had review. 2. The quality a employee P, statinterview, on 5- 	e actions that result in the home health agency's oss the spectrum of care. agency's quality performance improvement e objective measures. d review and interview, ed to ensure the agency's eent and performance rogram included quarterly review by health epresenting the scope of 4 (2nd 2015, 3rd 2015, st 2016) of 4 quarters clude: s clinical record review for the 2nd, 3rd, and 4th and the 1st quarter of evidence a physical obtional therapist, medical or speech language participated in the record assurance registered nurse, ated per telephone -20-16 at 3:05 PM. and I are the only ones	N 0472	All clinical staff will be educa on the following: •The requirements of 410 17-12-2 (a) QA and Perform Review •The agency's quality assessment and performand improvement program will in quarterly clinical record revie health professionals represe the scope of the program. •Agency Policy B-260 (QA •Agency Policy B-220 (Clin Record Review) Quarterly clinical record review will be conducted by approp health professionals, represe at least the scope of the pro on both active and closed cl records beginning with Quar 2016 record reviews by 6/19 and moving forward. The Cl Improvement and Performan Review (QAPI) committee w monitor ongoing compliance N472, on a quarterly basis, I ensuring that the appropriato health professionals, represe the scope of the program, re- clinical records at least quar This will be monitored by ad this itom to the QAPI commit	IAC ance ance clude ew by enting PI) nical eviews riate enting gram, inical ter 1, 0/16 Quality nce fill e with by e enting eviews ter 1, 0/16 Quality nce fill e with by e	06/19/2016

State Form

that do clinical record reviews. We do

not have any therapists or anyone else

that does it."

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this item to the QAPI committee

meeting agenda The Clinical

responsible for monitoring these corrective actions to ensure that

Director/designee will be

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLIE	r † of Indiana, LLC	14649	t address, city, state, zip code 9 HIGHWAY 41 NORTH ISVILLE, IN 47725		
(X4) ID PREFIX TAG	(EACH DEFICIE	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 B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION	
	 5-20-16 at 3:15 provided physic therapy, speech social services to 3rd, and 4th qua quarter of 2016 4. The agency's Review" policy least quarterly to ensure, appropri- representing at 	s September 2013 "Record and procedure states, "At he Clinical Director will iate Health professionals, least the scope of the y a sample of both active		this deficiency is corrected.		
N 0504 Bldg. 00	 exercise his or he home health age (2) The patient following: (D) Be informed furnished, and of be furnished as f (i) The home he the patient in adv (AA) disciplines (BB) frequency furnished. Based on record the agency failed been informed formed formed	patient has the right to er rights as a patient of the ncy as follows: has the right to the about the care to be any changes in the care to ollows: alth agency shall advise	N 0504	All clinical staff have been educated on the following: •The requirements of 410 17-12-3 (b)(2)(D)(i) Patient F •That all patients must be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOR MEDICARE & MEDICARD SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00	x3) date survey completed 05/20/2016
	PROVIDER OR SUPPLIE	r I OF INDIANA, LLC	14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	 4, 6, 7, 8, & 9) of The findings ind 1. Clinical reco "Admission Ser 5-4-16. The ser skilled nursing, therapy, and how were to be provided of the services the 2. Clinical reco "Home Health A Agreement" data agreement ident physical and occupational to be provided. 3. Clinical reco "Admission Ser 4-26-16. The sec identified skiller and occupational be provided. The evidence the pro- to be provided. The evidence the pro- to be provided. The scidentified skiller A. Clinical reco 	rd number 1 included an vice Agreement" dated vice agreement identified physical and occupational me health aide services ided. The agreement ce the proposed frequency	TAG	informed, in advance, of the proposed frequency of visits, in writing, on the Admission Servi Agreement Clinical staff will include the proposed frequency of visits on the Admission Service Agreement for all patients admitted to the agency. The agency's Admission Service Agreement has been revised to include a line for each discipling frequency. Each SOC will be audited, weekly for 6 weeks, un compliance threshold of 90% is achieved, for the presence of th proposed frequency of visits of each discipline on the Admission Service Agreement. After achieving compliance threshold audits will continue of 10% of clinical records quarterly. The Clinical Director/designee is responsible for correcting this deficiency and for monitoring th corrective action to ensure that this deficiency is corrected.	ce i b e's htill he bn d, ne

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE informed of the care to be furnished or the proposed frequency of visits proposed to be furnished. 5. Clinical record number 7 included a "Home Health Admission Service Agreement" dated 11-5-15. The service agreement identified skilled nursing, physical and occupational therapy, home health aide services, and medical social services were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 6. Clinical record number 8 included an "Admission Service Agreement" dated 2-12-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 7. Clinical record number 9 included an "Admission Service Agreement" dated 4-6-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 8. The Clinical Director was unable to State Form Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 65 of 104

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF PROVIDER OR SUPPLIER VIAQUEST HOME HEALTH OF INDIANA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725				
(X4) ID PREFIX TAG	(EACH DEFICIE	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 APPROPRI DEFICIENCY)		
N 0518 Bldg. 00	and/or informat 5-19-16 at 2:40 10:35 AM. 410 IAC 17-12-30 Patient Rights Rule 12 Sec. 3(e (e) The home h and distribute wri patient, in advarn on advance direct description of ap home health age directives information is fur provided. Based on record the agency failed been provided wa applicable Stated	ealth agency must inform tten information to the ce, concerning its policies tives, including a blicable state law. The ncy may furnish advanced ation to a patient at the time visit, as long as the hished before care is I review and interview, d to ensure patients had with a description of law with regards to ves in 12 (#s 1 through ls reviewed.	N 0518	All agency staff were educate the following: The requirements of 410 b 17-12-3 (e) Patient Rights That the agency must info and distribute written informa to the patient, in advance of a being provided, concerning it policies on advance directive including a description of	AC rm tion care s	
	1. Clinical reco 12 evidenced th provided with th ViaQuest Home upon admission	rds numbered 1 through e patients had been ne agency's "Welcome to e Health Services" booklet . The booklet included an etive Information		applicable State law ·Agency Policy C-430 (Adv Directives) The Indiana State Departmen Health (ISDH) description of applicable State law, "Your R to Decide" dated July 2013 w included in all admission pac to be provided to all patients	nt of Right rill be	

DEPARTMENT OF HEALTH AND HU	MAN SERVICES	
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES	
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLI	_{er} H of Indiana, LLC	14649	address, city, state, zip code Highway 41 North Sville, in 47725	
(X4) ID PREFIX TAG	(EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR 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
	Statement." T evidence the In Health (ISDH) State law, "Yo 2013. 2. The Clinica 5-19-16 at 2:40 provided to pa advance direct ISDH prepared State law, "Yo 2013. 3. The agency Directives" po C-430 (C) state prior to coming patient will be information co rights under sta case law) to m medical care, i or refuse medi	he booklet failed to adiana State Department of description of applicable ur Right To Decide" July 1 Director indicated, on 0 PM, the information tients with regards to ives did not include the 1 description of applicable ur Right To Decide" July 's June 2013 "Advance licy and procedure number es, "During the initial visit, g under ViaQuest Care, the provided with written ncerning the patient's ate law (both statutory and ake decisions concerning ncluding the right to accept cal or surgical treatment o formulate advance		admitted to the agency prior to care being provided. The ISE description of applicable State law, "Your Right to Decide" da July 2013 was distributed to a current patients of the agency 50% of admission packets will audited weekly for 6 weeks, o until compliance threshold of 9 is achieved, to ensure inclusio the appropriate ISDH advance directive information. After compliance threshold is achie audits will continue of 10% of admission packets quarterly. The Clinical Director/designee responsible for correcting this deficiency and for monitoring the corrective action to ensure that this deficiency is correcte	D DH ted II be r 90% on of e ved,
N 0522 Bldg. 00	410 IAC 17-13- Patient Care Rule 13 Sec. 1(a	(a) a) Medical care shall follow			
Diag. 00	a written medica and periodically dentist, chiropra podiatrist, as fol	I plan of care established reviewed by the physician, ctor, optometrist or ows:			
	Based on record	d review and interview,	N 0522	All agency clinical staff will be	06/19/201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		A. BUILDING	00	COMPLETED	
15/223			B. WING		05/20/2016
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				HIGHWAY 41 NORTH	
VIAQUEST HOME HEALTH OF INDIANA, LLC		EVANS	SVILLE, IN 47725		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	the agency faile	d to ensure services and		educated on the following:	•
	treatments had	been provided in		Requirements of 410 IAC	hall
	accordance with	n physician orders in 5 (#s		17-13-1(a) • Medical care s	
		12) of 12 records		follow a written medical plan care established and period	
	reviewed.	,		reviewed by the physician;	
				services and treatments will	be
	The first in the	- 1		provided in accordance with	
	The findings in			physician orders • Agency	
				C-635 (Physician Orders)	
		ord number 2 included a		clinical record review of 25%	
	-	ablished by the physician		active patients will be conducted to determine compliance with	
	for the certification	tion period 4-16-16 to		requirements of N522 Clin	
	6-13-16. The p	lan of care states, "Skilled		Record number 2:	
	assessment with			A.The physician was notified	d that
		rt failure]: medication		the SN failed to assess and	
	-	dema, weight, dyspnea		monitor the patient's weight	
	•			the plan of care. Physician of	
		ssessment, oxygen safety		was obtained to discontinue	dally
		nt Instruct to record		weights. B.One on one education wil	lhe
		d to report weight gain of		provided to the SN who faile	
	2 lbs. in one day	y or 5 lbs in one week or		assess and address the pat	
	as per physiciar	n order.'		urinary incontinence as it wa	
				identified on the assessmer	
	A. Skilled n	urse (SN) visit notes,		included in the plan of care.	
		4-21-16, 4-25-16,		will assess and address pat	
		, 5-5-16, 5-9-16, 5-12-16,		incontinence on every visit. drew HbA1c prior to initially	
		iled to evidence the SN		ordered date, per written	
	-			physician order obtained by	
		d monitored the patient's		patient, so results would be	
	weight.			available for physician's	
				appointment.SN failed to	
	B. A SN rec	certification visit note		discontinue the original orde	er for
	dated 4-14-16 s	tates, "Patient is		the lab to be drawn on	41
	incontinent [uri	nary]." The plan of care		5/19/16and SN failed to plac	
		tion period 4-16-16 to		written order in the clinical r or call to clarify, via verbal c	
		ed interventions to address		that the HbA1c was to be dr	
				early. One on one education	
	uie incontinence	e. The plan states,			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE CO A. BUILDING B. WING	00	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF PROVIDER OR SUPPLIER			14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	(X5) COMPLETION DATE
	"Assess instruct management, i. suggest they we undergarments Assess/instruct patient, to give reminders durin them to bathrood SN visit n 4-21-16, 4-25-1 5-5-16, 5-9-16, failed to eviden and addressed t The SN visit no urinary status w limits]." C. The plan certification per states, "Hgb A1 how well diabe due 5/19/16." 1.) A SN states, "SN drew of physician] vir record failed to venipuncture of 2.) The record	t on incontinence e. kegals, time-voiding, ear protection in at night caregivers not to rush frequent cues and og an activity, accompany om (allow privacy)." notes, dated 4-18-16, 6, 4-28-16, 5-2-16, 5-12-16, and 5-16-16, ce the SN had assessed he urinary incontinence. tes identifies the patient's vas "WNL [within normal of care for the riod 4-16-16 to 6-13-16 C [blood test to assess tes is being controlled] I visit note dated 5-12-16 w ordered labs from [name a venipuncture." The include an order for the n 5-12-16.		be provided to this SN and SN obtain written or verbal orders all changes to the plan of care Clinical Record number 3: A. SN failed to document how dressing change was perform Education provided to all clinic staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. B. SN failed to document that Hydrogel was applied to wour per physician order. Education provided to all clinical staff, or 5/24/16 and 5/25/16, regardin appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement following physician orders. Clinical Record number 5: A.Occupational therapy failed complete an evaluation per physician order; physician will notified that the Occupational Therapy evaluation was not completed. All therapy staff w be educated regarding followi physician orders and appropri documentation and physician notification when changes to t plan of care are necessary. B.The Occupational Therapy evaluation was not provided a indicated on the Admission Service Agreement and the physician will be notified that if was not completed. All clinical staff will be educated that	A will of for e. The ed. cal the nd n n g e of to l be ill ng iate the the the

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Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 69 of 104

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

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		A. B	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF PROVIDER OR SUPPLIER VIAQUEST HOME HEALTH OF INDIANA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725				
VIAQUE (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OF 3.) The re- Communication that states, "SN [name of physic SN to draw hgb on 5-19-16." The evidence the wr 2. Clinical reco physician's order states, "OK for order to Hyroge Aquacel Ag, co Dressing change week as previou A. SN visit 4-29-16, failed to dressing change notes state, "wo B. SN visit f 5-16-16, failed to applied the Hyd order. 3. Clinical reco "Home Health O date by the physic order states, "To	statement of deficiencies acy must be preceded by full a lsc identifying information) ecord included a "Case Report" dated 5-9-16 has written order from ian] given to patient for alc before upcoming appt he record failed to itten order. rd number 3 included a rs dated 4-25-16 that SN to change wound care l on wounds, then wer with foam dressing. e will remain 3 times per				er an w w ed to f at the med. ical e ull on bund n n n n g f	
	Therapy."	rd failed to evidence an			5/6/16, that the patient's legs been wrapped per the physic order; however, per this SN s did wrap the patient's legs pe	sian she	

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FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOF	R MEDICARE & MEDI	CAID SERVICES				ОМ	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	с ́		DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPL	
		157223	B. WIN			05/20/	2016
NAME OF F	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC			HIGHWAY 41 NORTH VILLE, IN 47725		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	-	erapy evaluation had been			physician order but failed to document the procedure. SN		
	completed.				instructed to annotate the visi	t	
					note of 5/6/16 to include this		
	B. The reco	rd included an			documentation. Patient had s	een	
	"Admission Ser	rvice Agreement", signed			physician on 5/3/16 and the		
	and dated by th	e patient on 4-21-16, that			physician had removed the w	raps	
	identifies an oc	cupational therapy			to patient's legs and failed to reapply them, per documenta	tion	
	evaluation wou	ld be provided.			in the clinical record. Education		
		•			provided to all clinical staff, or		
	C. The Clin	ical Director stated, on			5/24/16 and 5/25/16, regardin		
		0 AM, "The order was			appropriate documentation of		
	missed."				wound care performed. See supporting documentation. In		
					addition, all clinical staff will b		
	A Clinical reco	ord number 11 included a			educated on the requirement		
		ablished by the physician			following physician orders. 2		
	<u>^</u>	tion period 4-26-16 to			of all visit notes will be review	red	
					weekly for compliance of providing care in accordance	with	
	-	lan of care states, "Wound			physician orders/plan of care	vvitii	
		Right buttocks: Cleanse			beginning week of 6/13/16 for	га	
	-	l saline] and pat dry with			period of 6 weeks. Complian	се	
	0 11 5	risma to area, cover with			threshold is 90%. If Threshol	d of	
	foam."				90% is achieved for 6 consecutive weeks then chart	L	
					audits will be decreased to 10		
		sit note dated 4-30-16			quarterly chart reviews. The		
		ce how the wound care			Clinical Director/designee will		
	-	The note states, "wound			responsible for monitoring the		
	-	. pt [patient] tolerated			corrective actions to ensure this deficiency is corrected.	nat	
	well."						
	D A CNL-	sit note dated 5-2-16 failed					
		wound care had been					
		wound care had been					
	performed.						
	C. A SN vis	sit note dated 5-13-16					
	evidenced the f	oal dressing was applied,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILE 157223 B. WING NAME OF PROVIDER OR SUPPLIER	OMB NO. 0938-0 E CONSTRUCTION (X3) DATE SURVEY G 00 COMPLETED GET ADDRESS, CITY, STATE, ZIP CODE 05/20/2016 49 HIGHWAY 41 NORTH ANSVILLE, IN 47725
157223B. WINGIAME OF PROVIDER OR SUPPLIERVIAQUEST HOME HEALTH OF INDIANA, LLCXay IDSUMMARY STATEMENT OF DEFICIENCIEST(EACH DEFICIENCY MUST BE PRECEDED BY FULLREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGBut failed to evidence the Prisma was applied per the physician's order.5. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 	05/20/2016 EET ADDRESS, CITY, STATE, ZIP CODE 49 HIGHWAY 41 NORTH
IAME OF PROVIDER OR SUPPLIER S I/AQUEST HOME HEALTH OF INDIANA, LLC I X4) ID SUMMARY STATEMENT OF DEFICIENCIES T REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) T but failed to evidence the Prisma was applied per the physician's order. 5. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban." A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps. 6. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 7. The agency's August 2013 "Physician	EET ADDRESS, CITY, STATE, ZIP CODE 49 HIGHWAY 41 NORTH
IAME OF PROVIDER OR SUPPLIER 1 MAQUEST HOME HEALTH OF INDIANA, LLC 1 REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1 TAG But failed to evidence the Prisma was applied per the physician's order. 5 S. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban." A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps. 6. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 7. The agency's August 2013 "Physician	49 HIGHWAY 41 NORTH
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10:35 AM.7. The agency's August 2013 "Physician	
7. The agency's August 2013 "Physician	
L Urders" holley and procedure humber	
C-635 states,"All care and service	
provided will be in accordance with	
physician orders."	

State Form

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	R MEDICARE & MEDI					IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMPI	
	157223		B. WING	00	05/20	
NAME OF	PROVIDER OR SUPPLIE	ER		ET ADDRESS, CITY, STATE, ZIP CODE		
VIAQUE	ST HOME HEALTI	H OF INDIANA, LLC		NSVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX		E	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
N 0524	410 IAC 17-13-1	(a)(1)				
	Patient Care					
Bldg. 00	Rule 13 Sec. 1(a plan of care shal)(1) As follows, the medical				
		d in consultation with the				
	home health age					
	(B) Include all se	ervices to be provided if a				
	skilled service is					
		rtinent diagnoses.				
	(C) Include the f (i) Mental stat	-				
	· · /	ervices and equipment				
	required.					
	(iii) Frequency	and duration of visits.				
	(iv) Prognosis.					
		ion potential.				
	(vi) Functional (vii) Activities p					
	(viii) Activities p					
		is and treatments.				
		measures to protect				
	against injury.					
		s for timely discharge or				
	referral.	adalitica anacifuing langth of				
	treatment.	odalities specifying length of				
		ppropriate items.				
		d review and interview,	N 0524	Education will be provided to	C	06/19/201
		ed to ensure plans of care		agency clinical staff on the		
	• •	fic to the assessment and		following:		
	_	atments in 3 (#s 4, 6, and		•The requirements of 410 17-13-1(a)(1)-Patient Care	IAC	
				•That the plan of care,		
	8) of 12 records reviewed.			developed in consultation w	ith the	
	The findings in	clude:		agency staff, covers all perti	nent	
		ciude.		diagnoses, including mental		
	1 Clinical and	nd mumbor 1 in start - t -		status, types of services and		
		ord number 4 included a		equipment required, frequer visits, prognosis, rehabilitation		
		nprehensive assessment		potential, functional limitatio		
		The assessment identifies		activities permitted, nutrition		
	1.4 .4 .4 4	no urinary incontinence.	1	requirements, medications a		1

CENTERS FC	OR MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-0391
	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	r H of Indiana, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	•
(X4) ID PREFIX TAG	(EACH DEFICIE	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	 physician for the 4-26-16 to 6-24 interventions resolver of urinary inconstates, "Assess management, i. suggest they we undergarments caregivers not the frequent cues a activity, accombathroom allow 2. Clinical reconstant of care condated 3-31-16. The plan of care physician for the 3-31-16 to 5-29 interventions resolver of urinary inconstates, "Assess management, i. suggest they we undergarments caregivers not the frequent cues a activity, accombathroom allow 3. Clinical reconstant of care combathroom allow 	elated to the management ntinence. The plan of care instruct on incontinence e. kegals, time-voiding, ear protection in at night assess/instruct o rush patient, to give nd reminders during pany them to the privacy." ord number 6 included a nprehensive assessment The assessment identifies no urinary incontinence. e, established by the ne certification period 0-16, includes elated to the management ntinence. The plan of care instruct on incontinence e. kegals, time-voiding, ear protection in at night assess/instruct o rush patient, to give nd reminders during pany them to the		treatments, any safety measu to protect against injury, instructions for timely dischar or referral and any other appropriate items •The plan of care must be specific to the assessment of patient's needs •Agency Policy C-580 (Plar Care) •Agency clinical software generated care plans/guidelin will be revised to exclude inappropriate auto-populated interventions to allow the individualizing of patient-speci interventions. A clinical record review of 25 active patients will be conduc to determine compliance with requirements of N524: that th plan of care is based on the patient's comprehensive assessment and contains all the required elements. Clini Record #4: This patient had n urinary incontinence. A physi order will be obtained to correct the plan of care to remove th interventions related to urinar incontinence. The agency clin software generated intervent un-related to the patient's assessment that were erroneously included in the p of care. The agency clinical software will be revised to exclude inappropriate, auto-populated interventions allow individualization. Clinical Record #6: This patient had no urinary incontinence.	rge i the n of nes cific % of ted ne l of cal no cian ect ery nical ions lan to ent

State Form

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 74 of 104

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	00	_	pleted 0/2016
		157225			_	0/2016
AME OF	PROVIDER OR SUPPLIE	ER.		ADDRESS, CITY, STATE, ZIP C	CODE	
				HIGHWAY 41 NORTH		
/IAQUE	ST HOME HEALTH	H OF INDIANA, LLC	EVANS	SVILLE, IN 47725		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	for the certifica	tion period 4-12-16 to		physician order will be		
	6-10-16. The p	lan of care included		correct the plan of care		
	-	pational therapy visits 2		the interventions relate	-	
		for 4 weeks. The orders		incontinence. The age		
	•			software generated int		
	-	onal therapy failed to		un-related to the patie assessment that were		
	-	cific treatments to be		erroneously included in	n the plan	
	provided.			of care. The agency cli		
				software will be revise		
	4. The Clinical	Director was unable to		exclude inappropriate,		
	provide any add	litional documentation		auto-populated interve	entions to	
		tion when asked on		allow individualization.		
				Clinical Record #8: A	•	
		PM and on 5-20-16 at		order will be obtained		
	10:35 AM.			the plan of care to incl		
				specific Occupational treatments to be provide		
	5. The agency's	s 3-28-13 "Plan of Care"		therapists will be educ		
	policy and proc	edure number C-580		requirement to include		
	(HH) states. "T	he Plan of Care is based		treatments to be provid		
	. , .	nsive assessment and		therapy orders for serv		
	information pro			Beginning with plans of		
	-	•		dated 6/13/16 and late		
		ind health team members .		all Plan of Cares will b		
		Care shall be completed in		weekly to ensure that	-	
	full to include:	Specific procedures		care is specific to the a and the patient's need		
	and modalities	for therapy services		audit will also ensure t		
	.Medications, tr	reatments, and		plans of care include t		
	procedures."			pertinent diagnoses, ir		
	r · · · · · · · ·			mental status, types of	•	
				servicesand equipmer	nt required,	
				frequency of visits, pro	•	
				rehabilitation potential		
				limitations, activities pe	ermitted,	
				nutritional	one and	
				requirements, medicati		
				treatments, any safety to protect against injur		
				instructions for timely		
				or referral and any oth	-	

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 75 of 104

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	r í	ILDING	00		PLETED
	157223		B. WI	NG		05/2	0/2016
NAME OF P	ROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD	ЪЕ	
VIAQUES	ST HOME HEALTH	i of Indiana, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID		TION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					appropriate items. This au continue for a period of 6 Threshold is 90%. If thre 90% is met 6 consecutive in a row, the chart audits decreased to a 10% quar chart audit. The Clinical Director/designee will be responsible for monitoring corrective actions to ensu- this deficiency is corrected	e weeks. eshold of e weeks can rterly g these ure that	
Bldg. 00	professional staff shall promptly all for the medical co care to any chang alter the medical Based on record the agency faile alerted the phys patients' needs a 3, 6, and 8) of 1 The findings ind 1. Clinical reco evidence the reg informed the phys size of the patie in the character A. A skilled recertification v	I review and interview, d to ensure staff had ician to changes in the and condition in 4 (#s 2, 2 records reviewed. Clude: rd number 2 failed to gistered nurse (RN) had ysician of a change in the nt's wound and a change of the wound drainage.	N 05	527	All agency professional s be educated on the follow Requirements of 410 L 17-13-1 (a)(2) Patient Ca Agency professional s promptly alert the physici any changes that sugges to alter the plan of care Agency Policy C-580 (Care) Appropriate use of cas communication notes and appropriate care coordina Agency clinical software-generated care plans/guidelines have be modified to include appro- interventions, including interventions directed at on whom a weight is not be obtained	ving: AC taff must taff must ian to st a need Plan of Plan of d ation en opriate patients	06/19/2010

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	A. BUILDING B. WING	STRUCTION (X3) DATE SURVEY 00 COMPLETED 05/20/2016	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
/IAQUE	ST HOME HEALTH	H OF INDIANA, LLC		HIGHWAY 41 NORTH SVILLE, IN 47725	
X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		ind 0.2 cm in width. The		of active patients will be conducted to determine	
		he wound as an abrasion		compliance with the requireme	nts
	with a scant am	ount of serous drainage.		of N527: that agency professio	
				staff promptly alert the physicia	an
	B. A SN vis	sit note dated 4-25-16		to any changes that suggest a	
	evidenced the w	yound was located on the		need to alter theplan of care. Agency professional staff will a	lort
	patient's left kn	ee, was 0.5 cm in length		the physician to any changes t	
	and 0.2 cm in w	vidth with a "moderate		suggest a need to alter the pla	
	amount serous	ourulent (yellow/tan)		of care and document the	
	drainage."	· · · ·		physician notification in the	
	C			clinical record in the visit note	or
	C A SN vis	sit note dated 5-5-16		using a case communication note. Clinical Record #2 (A-D	`
		yound was located on the		The SN documented the)
		as 3.5 cm in width and 0.5		presence of the wound in the	
		th a "small" amount of		60-day summary provided to th	ne
	-			physician; however, the wound	
	purulent (yend	w/tan) drainage."		measurements were not includ The SN failed to document	ed.
	D 0 5 10	16 4 10 45 DM 1		evidence of physician notificati	on
		16 at 12:45 PM, during a		related to changes in the size a	
	-	atient number 2, employee		condition of the patient's woun	d.
		ed, "The open area was		No harm came to this patient a	
		weeks ago it started		result of the failure of the SN to	
		fluid. I did tell the		document the required physician violation and the physicia	
		e patient] goes to see the		notified of the changes in the	
	PCP [primary c	are physician] tomorrow."		patient's wound. This SN was	
				educated and counseled on the	e
	2. Clinical reco	ord number 3 included a		requirements of N527: to	
	plan of care esta	ablished by the physician		promptly alert the physician to any changes that suggest a ne	bed
	for the certification	tion period 3-22-16 to		to alter the plan of care and	
	5-20-16. The p			appropriate documentation of t	hat
	_	address congestive heart		notification. Clinical Record #	
		g daily weights. The plan		(A-B) This patient is unable to	
		to record weight daily		obtain weight daily but	
		eight gain of 2 lbs in one		interventions on the plan of car did include daily weights. The	
	day or 5 lbs in c			did identify this but failed to no	

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	R MEDICARE & MEDI				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVANS	SVILLE, IN 47725	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	E COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	physician order			the physician of the patient's	
				inability to complete daily we	
	A. A SN vis	sit note dated 4-6-16		The physician has been noti	fied
		tient is unable to weigh		of the patient's inability to	nd
	-	-		complete the daily weights a the plan of care amended to	
	-	orbid obesity" and "it		reflect the patient's inability f	
		nsafe for [the patient] to		so. Clinical Record #6 (A-C	
	stand on a scale	due to morbid obesity		plan of care contained	,
	and living alone	2."		interventions to address bloc	bd
				glucose control, including blo	bod
	B The reco	rd failed to evidence the		glucose testing. The SN	
				documented that the patient	does
		een informed of the		not comply with blood glucos	
	-	ty to complete daily		testing and did exhibit s/s re	
	weights to mon	itor for fluid retention and		to hypoglycemia. The SN fai	
	signs and symp	toms of congestive heart		document physician notificat	ion of
	failure.			the patient's reluctance to	~
				perform blood glucose testin The physician has been noti	
	3 Clinical reco	ord number 6 included a		of the patient's noncomplian	
				with blood glucose testing. T	
	-	ablished by the physician		SN is no longer employed by	
		tion period 3-31-16 to		agency. All nursing staff hav	
	5-29-16. The p	lan of care evidenced		been educated regarding the	
	interventions to	address blood glucose		requirement to notify the	
		an states, "SN to perform		physician of any changes in	
	-	iabetes: blood glucose		patient condition that sugge	
		•		need to alter the plan of care	
	testing and eval	uau011.		Clinical Record #8 (A-C) The	
				failed to document physician	
		notes, dated 4-6-16,		notification of improvement t patient's wound and wound	
	4-8-16, 4-13-16	, 4-18-16, 4-27-16,		no longer being needed and	
	5-6-16, and 5-1	3-16 evidenced the patient		failed to document wound ca	
		blood sugar regularly"		performed on the 5/13/16 vis	
		ient can tell by "how [the		The wound care was not	-
	-	ient can ten by now [the		discontinued and the patient	
	patient] feels."			performed wound care on 5/	
				as observed and documente	
	B. An "Adn	nission Note Report"		the SN. The physician has b	een
	dated 3-31-16 s	tates, "Patient had fallen		notified of the	

State Form

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	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 B. WING 05/20/2016		ETED		
		R H OF INDIANA, LLC		14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725		
	-				T		(115)
X4) ID REFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	OOB [our of be	ed] and was noted to have			condition/improvement of the		
	-	n the 40's. New			wound. This SN has been		
	compression fra				educated regarding the	201	
	1				requirement of N527: that age professional staff must prompt	-	
	C. The reco	rd failed to evidence the			alert the physician to any chan		
		been informed of the	1		that suggest a need to alter the	e	
		ince to perform blood	1		plan of care. PT failed to notif	5	
	sugar testing.	r			the physician that PT services were discontinued per patient		
			1		request. The physician has be	en	
	4. Clinical reco	ord number 8 included a			notified and the therapist		
		ablished by the physician			educated regarding the		
	-	tion period 4-12-16 to			requirement of N527: that the physician must promptly be		
		lan of care states, "SN/CG			alerted to any changes that		
	-	patient] to cleanse wound			suggest a need to alter the pla	n	
		ormal saline] and gauze			of care. 25% of all visit notes	3	
	-	chnique. Using aseptic			will be reviewed weekly for compliance of documentation	that	
	e .	Muprocin to wound bed,			the physician was informed	linat	
		gauze, wrap with Kerlix			promptly of any changes that		
	and secure with	•			suggest a need to alterthe plan care beginning week of 6/13/11		
		sit note dated 5-13-16			for a period of 6 weeks. Threshold is 90%. If Threshold	d of	
		as covered over with scab			90% is achieved for 6 consecutive weeks then chart		
		rainage notes. Pt advised			audits can be decreased to 10	%	
	-	y still be open some			quarterly chart reviews. The		
	underneath and	could open back up."			Clinical Director/designee will l responsible for monitoring thes	se	
	B. The reco	rd failed to evidence the			corrective actions to ensure the	at	
	physician had b	been notified of the	1		this deficiency is corrected.		
		e wound and that the					
	dressing change	e was no longer needed.					
	C. The plan	of care included orders					
	for physical the	erapy (PT) services 2 times					
	per week for 4	weeks. The record	1				

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If continuation sheet Page 79 of 104

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	T OF DEFICIENCIES			NETRICTION		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016	
NAMEOFI	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE		
		[™] I OF INDIANA, LLC		HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID		STATEMENT OF DEFICIENCIES			(X5)	
PREFIX TAG	(EACH DEFICIE	NATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
	included a PT d 4-25-16 that sta	ischarge note dated tes, "D/C [discontinue] per patient request."				
	physician had b	d failed to evidence the een notified PT services tinued prior to the end of ordered.				
	provide any add and/or informat	Director was unable to litional documentation ion when asked on PM and on 5-20-16 at				
	policy and proc (HH) states, "Pr promptly alert t	s 3-28-13 "Plan of Care" edure number C-580 rofessional staff shall he physician to any ggest a need to alter the				
N 0537 Bldg. 00	shall provide nurse registered nurse nurse in accorda care as follows: Based on record		N 0537	All agency clinical staff will be educated on the following:	06/19/201	
	treatments had accordance with	been provided in n physician orders in 4 (#s) of 12 records reviewed.		•Requirements of 410 iac 17-14-1(a): Scope of Services •The agency shall provide services by an RN or LPN in accordance with the medical p		

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 157223	(X2) MULTIPLE CO A. BUILDING B. WING	00	X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLI ST HOME HEALT	er 'H of Indiana, llc	14649 ⊢	ADDRESS, CITY, STATE, ZIP CODE HGHWAY 41 NORTH VILLE, IN 47725		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY OF The findings in 1. Clinical rec plan of care ess for the certifica 6-13-16. The p assessment wit [congestive hear management, et levels, cardiac and management weight daily ar 2 lbs. in one da as per physicia A. Skilled find dated 4-18-16, 4-28-16, 5-2-16 and 5-16-16, fa had assessed an weight. B. A SN re dated 4-14-16 fa incontinent [ur for the certifica 6-13-16 includ the incontinent.]	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) Include: ord number 2 included a tablished by the physician ation period 4-16-16 to plan of care states, "Skilled th focus on CHF art failure]: medication edema, weight, dyspnea assessment, oxygen safety ent Instruct to record nd to report weight gain of ay or 5 lbs in one week or n order.' nurse (SN) visit notes, 4-21-16, 4-25-16, 6, 5-5-16, 5-9-16, 5-12-16, ailed to evidence the SN nd monitored the patient's certification visit note states, "Patient is inary]." The plan of care ation period 4-16-16 to ed interventions to address ce. The plan states, et on incontinence .e. kegals, time-voiding, ear protection in	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) of care. Agency Policy C-580 (Plan Care) Clinical Record number 2: A. The physician was notified the SN failed to assess and monitor the patient's weight p the plan of care. Physician or was obtained to discontinue of weights. B. One on one education will provided to the SN who failed assess and address the patie urinary incontinence as it was identified on the assessment included in the plan of care. S will assess and address patie incontinence on every visit. C. SN drew HbA1c prior to in ordered date, per written physician order obtained by patient, so results would be available for physician's appointment.SN failed to discontinue the original order the lab to be drawn on 5/19/1 and SN failed to place the wri order in the clinical record or to clarify, via verbal order, tha HbA1c was to be drawn early One on one education will be provided to this SN and SN w obtain written or verbal orders all changes to the plan of care Clinical Record number 3: A. SN failed to document how dressing change was perform Education provided to all clini staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care	for 6	

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 81 of 104

PRINTED: 06/17/2016

NTERS FO	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE	R H OF INDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
VIAQUE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O reminders durin them to bathrood SN visit n 4-21-16, 4-25-1 5-5-16, 5-9-16, failed to eviden and addressed t The SN visit no urinary status w limits]." C. The plan certification per states, "Hgb A1 how well diabe due 5/19/16." 1.) A SN states, "SN drew of physician] vi record failed to venipuncture of 2.) The re the Hgb A1C has per the plan of of 3.) The re	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ag an activity, accompany om (allow privacy)." notes, dated 4-18-16, .6, 4-28-16, 5-2-16, 5-12-16, and 5-16-16, .ce the SN had assessed he urinary incontinence. otes identifies the patient's vas "WNL [within normal of care for the riod 4-16-16 to 6-13-16 .C [blood test to assess tes is being controlled] I visit note dated 5-12-16 w ordered labs from [name ia venipuncture." The include an order for the n 5-12-16.	EVANS	WILLE, IN 47725 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) documentation. B. SN failed to document that the Hydrogel was applied to woun per physician order. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 11: A. SN failed to document how the dressing change was performed. Education provided all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. B. SN failed to document that wound care performed. B. SN failed to document that wound care performed. B. SN failed to document that wound care had been perform Education provided to all clinic staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinic staff will be educated on the requirement of following physic orders. C. SN failed to document would care appropriately. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff, on 5/24/16 and5/25/16, regarding appropriate document of following physician orders. Clinical Record number 12: The SN failed to document, or	the d d d d d d d d d d d d d d d d d d d

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 82 of 104

	R MEDICARE & MEDIO				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G <u>00</u>	COMPLETED
		157223	B. WING		05/20/2016
	PROVIDER OR SUPPLIE	P	STRE	EET ADDRESS, CITY, STATE, ZIP	CODE
NAME OF	I KO VIDEK OK SOI I EIE	R	146	49 HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVA	ANSVILLE, IN 47725	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION (X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFL	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
	evidence the wr	itten order.		order; however, per th	
				did wrap the patient's physician order but fa	
	2. Clinical reco	ord number 3 included a		document the procedu	
	physician's orde	ers dated 4-25-16 that		instructed to annotate	
	states, "OK for	SN to change wound care		note of 5/6/16 to inclu	
	-	el on wounds, then		documentation. Patier	
		ver with foam dressing.		physician on 5/3/16 a	
		e will remain 3 times per		physician had remove to patient's legs and fa	
		isly scheduled."		reapply them, per doc	
		asiy seneduled.		in the clinical record.	
		notes dated 1 07 1(1		provided to all clinical	
		notes, dated 4-27-16 and		5/24/16 and 5/25/16, i	
		to evidence how the		appropriate document	
		e was performed. The		wound care performed addition, all clinical sta	
	notes state, "wo	und care performed."		educated on the requi	
				following physician or	
	B. SN visit	notes, dated 5-13-16 and		of all visit notes will be	
	5-16-16, failed	to evidence the SN had		weekly for compliance	
	applied the Hyd	lrogel per the physician's		providing care in acco	
	order.			physician orders/plan beginning week of 6/1	
				period of 6 weeks. Co	
	3. Clinical reco	ord number 11 included a		threshold is 90%. If T	-
		ablished by the physician		90% is achieved for 6	
	-	tion period 4-26-16 to		consecutive weeks the	
		lan of care states, "Wound		audits will be decreas	
	-	Right buttocks: Cleanse		quarterly chart review Clinical Director/desig	
		•		responsible for monito	
	-	saline] and pat dry with		corrective actions to e	
		isma to area, cover with		this deficiency is corre	
	foam."				
		it water data 1.4.20.16			
		sit note dated 4-30-16			
		ce how the wound care			
	-	The note states, "wound			
	-	pt [patient] tolerated			
	well."				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG B. A SN visit note dated 5-2-16 failed to evidence the wound care had been performed. C. A SN visit note dated 5-13-16 evidenced the foal dressing was applied, but failed to evidence the Prisma was applied per the physician's order. 4. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban." A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. State Form Event ID: Facility ID: IN005940 If continuation sheet EDWQ11 Page 84 of 104

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

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	A. BUILDING 00 COMPLETED B. WING 05/20/2016			
	PROVIDER OR SUPPLIE	r I OF INDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY 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	
N 0542 Bidg. 00	Orders" policy a C-635 states,"A provided will be physician orders 410 IAC 17-14-1(Scope of Service Rule 14 Sec. 1(a) services are limit purposes of pract setting, the regist following: (C) Initiate the pl revisions. Based on record the agency faile nurse (RN had is revisions to the 6, and 8) of 12 n The findings ind 1. Clinical record evidence the regist informed the ph size of the patie in the character	a)(1)(C) s (1)(C) Except where ed to therapy only, for ice in the home health ered nurse shall do the an of care and necessary l review and interview, d to ensure the registered nitiated necessary plan of care in 4 (#s 2, 3, records reviewed.	N 0542	All agency professional staff wil be educated on the following: • Requirements of 410 IAC 17-14-1(a)1(C)-Scope of Servic • The RN initiates the plan of care and necessary revisions • Agency Policy C-360 (Coordination of Patient Care) clinical record review of 25% of active patients will be conducted to determinecompliance with the requirements of N542: that the RN initiates the plan ofcare and necessary revisions. Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician;	A d e	
		l nurse (SN) isit note dated 4-14-16 round was located on the		however, the wound measurements were not include The SN failed to document evidence of physician notification related to changes in the size a	n	

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

	NT OF DEFICIENCIES NOF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
		I OF INDIANA, LLC	14649	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	55
	left shin and me (cm) in length a note classified t with a scant am B. A SN vis evidenced the w patient's left km and 0.2 cm in w amount serous p drainage." C. A SN vis evidenced the w left knee and w cm in length wi "purulent (yellow D. On 5-18- home visit to pa K, the RN, state scabbed. Two draining yellow physician. [The PCP [primary c 2. Clinical reco plan of care esta for the certifica 5-20-16. The p interventions to failure including	easured 0.5 centimeters nd 0.2 cm in width. The he wound as an abrasion ount of serous drainage. it note dated 4-25-16 yound was located on the ee, was 0.5 cm in length ridth with a "moderate ourulent (yellow/tan) it note dated 5-5-16 yound was located on the as 3.5 cm in width and 0.5 th a "small" amount of w/tan) drainage." 16 at 12:45 PM, during a ttient number 2, employee ed, "The open area was weeks ago it started fluid. I did tell the e patient] goes to see the are physician] tomorrow." ord number 3 included a ablished by the physician tion period 3-22-16 to		condition of the patient's would No harm came to this patient result of the failure of the SN to document the required physic notification and the physician notified of the changes in the patient's wound. This SN was educated and counseled on the requirements of N542: The RM initiates the plan of care and necessary revisions Clinical Record #3 (A-B) This patient is unable to weight daily but interventions on the plan of care did include daily weights. The did identify this but failed to not the physician of the patient's inability to complete daily weights an plan of care amended to refle the patient's inability to do so. Clinical Record #6 (A-C) The of care contained intervention address blood glucose testing The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed document physician notification the patient's reluctance to perform blood glucose testing The physician has been notifie of the patient's noncompliance with blood glucose testing. The SN is no longer employed by agency. All nursing staff havebeen educated regarding requirement to notify the	nd. as a o cian was ine N N is are SN otify ghts. ed dthe ct is plan is to l, g. to on of l. ed e his this

State Form

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 86 of 104

PRINTED: 06/17/2016

FORM APPROVED

OMB NO. 0938-0391

	MEDICARE & MEDI				OMB NO. 0938-03
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
NAME OF P	ROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				HIGHWAY 41 NORTH	
VIAQUES	ST HOME HEALTH	H OF INDIANA, LLC	EVAN	SVILLE, IN 47725	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	OBE COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	day or 5 lbs in c	one week or as per		physician of any changes i	
	physician order	."		patient condition that sugg	
				need to alter the plan of ca Clinical Record #8 (A-C) T	
	A. A SN vis	sit note dated 4-6-16		failed to document physicia	
		tient is unable to weigh		notification of improvement	
	-	orbid obesity" and "it		patient'swound and wound	
		•		no longer being needed an	
	would also be unsafe for [the patient] to stand on a scale due to morbid obesity		failed to document wound		
		•		performed on the 5/13/16	/isit.
	and living alone	2."		The wound care was not	nt
				discontinued and the patie performed wound care on	
	B. The reco	rd failed to evidence the		as observed and documen	
	physician had been informed of the patient's inability to complete daily		the SN. The physician has	-	
		ty to complete daily		notified of the	
	-	itor for fluid retention and		condition/improvement of t	he
	•	toms of congestive heart		wound. This SN has been	
		the RN had initiated a		educated regarding the	
		an of care to address the		requirement of N542: The initiates the plan of care ar	
				necessary revisions PT fa	
	•	ty to complete daily		notify the physician or the	
	weights.			PT services were discontin	
				per patient request. The ph	nysician
		ord number 6 included a		has been notified and the	
	plan of care esta	ablished by the physician		therapist educated regarding	
	for the certification	tion period 3-31-16 to		requirement of N542: The initiates the plan of care ar	
	5-29-16. The p	lan of care evidenced		necessary revisions 25%	
	-	address blood glucose		RN visit notes will be review	
		an states, "SN to perform		weekly, beginning week of	
	-	iabetes: blood glucose		6/13/16, for compliance of	
	testing and eval	-		RN initiating necessary rev	
	icsung and eval	uation.		to the plan of care, for a p	
				6 weeks. Threshold is 90% Threshold of 90% is achiev	
	A. SN visit notes, dated 4-6-16,		6 consecutive weeks then		
		6, 4-18-16, 4-27-16,		audits can be decreased to	
	5-6-16, and 5-1	3-16 evidenced the patient		quarterly chart reviews.	
	does not "check	blood sugar regularly"		Clinical Director/designee	
	and that the pat	ient can tell by "how [the		responsible for monitoring	these

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 87 of 104

PRINTED: 06/17/2016 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION		TE SURVEY MPLETED	
AND PLAP	OF CORRECTION	157223	A. BUILDING <u>00</u> B. WING		00		20/2016	
NAME OF	PROVIDER OR SUPPLIE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE				
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC			HIGHWAY 41 NORTH SVILLE, IN 47725			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE PROPRIATE	COMPLETIC DATE	
1110	patient] feels."				corrective actions to ens	ure that	DAIL	
	putient] reels.				this deficiency is corrected	ed.		
	B. An "Adn	nission Note Report"						
	dated 3-31-16 s							
		ed] and was noted to have						
	a blood sugar in	-						
	compression fra							
	C. The reco	rd failed to evidence the						
	physician had b	een informed of the						
	patient's relucta	nce to perform blood						
		d the RN had initiated a						
	change in the p	lan of care to address the						
	patient's relucta	nce.						
	4. Clinical reco	ord number 8 included a						
	plan of care est	ablished by the physician						
	for the certifica	tion period 4-12-16 to						
	-	lan of care states, "SN/CG						
		patient] to cleanse wound						
	-	ormal saline] and gauze						
	- ·	chnique. Using aseptic						
		Muprocin to wound bed,						
		gauze, wrap with Kerlix						
	and secure with	tape."						
	A. A SN vis	sit note dated 5-13-16						
	notes "wound h	as covered over with scab						
	and no active d	rainage notes. Pt advised						
	that wound may	y still be open some						
	underneath and	could open back up."						
	B. The reco	rd failed to evidence the						
	physician had b	een notified of the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's September 2013 "Coordination of Patient Care" policy and procedure number C-360 (HH) states, "The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communication changes to caregivers within twenty-four (24) hours following the conference or changes. The physician will be contacted when his/her approval for the change is necessary and to alert physician to changes in the patient condition."

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Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 89 of 104

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMPL	(X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC		HIGHWAY 41 NORTH SVILLE, IN 47725			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
N 0546 Bldg. 00	services are limit purposes of prace setting, the regist following: (G) Inform the pl appropriate medi the patient's cond the patient's cond the patient and fa and related need programs, and su nursing personne Based on record the agency faile nurse (RN)had changes in the p condition in 4 (records reviewed The findings in 1. Clinical record evidence the reg- informed the ph size of the patie in the character A. A skille recertification w evidenced the w left shin and me	(1)(G) Except where ed to therapy only, for tice in the home health tered nurse shall do the hysician and other cal personnel of changes in dition and needs, counsel amily in meeting nursing s, participate in inservice upervise and teach other el. d review and interview, ed to ensure the registered alerted the physician to patients' needs and #s 2, 3, 6, and 8) of 12 ed.	N 0546	All agency clinical staff will be educated on the following: Requirements of 410 IAC 17-14-1(a)(1)(G)-Scope of Services The RN alerts the physicia changes in the patient's cond and needs. A clinical record review of 250 active patients will be conduc to determine compliance with requirements of N546: that th RN alerts the physician to changes in the patient's need and condition Clinical Recor (A-D) The SN documented th presence of the wound in the 60-day summary provided to physician; however, the wour measurements were not inclu The SN failed to document evidence of physician notifica related to changes in the size	an to ition of % of ted the e ds d #2 e the id ided. tion	06/19/2016	

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State Form

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

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
NAME OF I	PROVIDER OR SUPPLIEI	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	
TO THE OF I	NOVIDER OR SOLLER		14649	HIGHWAY 41 NORTH	
VIAQUE	ST HOME HEALTH	I OF INDIANA, LLC	EVANS	SVILLE, IN 47725	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	note classified th	he wound as an abrasion		condition of the patient's wour	
	with a scant amo	ount of serous drainage.		No harm came to this patient	
		-		result of the failure of the SN t	
	B A SN vie	it note dated 4-25-16		document the required physic	
				notification and the physician notified of the changes in the	was
		ound was located on the		patient's wound. This SN was	
	-	ee, was 0.5 cm in length		educated and counseled on the	
	and 0.2 cm in w	idth with a "moderate		requirements of N546: to alert	
	amount serous p	ourulent (yellow/tan)		physician to any changes in th	
	drainage."			patient's needs and condition.	
	0	A SN visit note dated 5-5-16		Clinical Record #3 (A-B) This	
	C A SN vie			patient is unable to weigh dail	
	evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5			but interventions on the plan of	
				care did include daily weights.	
				The SN did identify this but fail	lled
	cm in length wit	h a "small" amount of		to notify the physician of the	daily
	"purulent (yello	w/tan) drainage."		patient's inability to complete weights. The physician has be	-
				notified of the patient's inabilit	
	D On 5-18-	16 at 12:45 PM, during a		complete the daily weights an	
		tient number 2, employee		the plan of care amended to	-
	-			reflect the patient's inability to	do
		d, "The open area was		so. Clinical Record #6 (A-C)	The
		veeks ago it started		plan of care contained	
	draining yellow	fluid. I did tell the		interventions to address blood	
	physician. [The	patient] goes to see the		glucose control, including bloc	bd
		are physician] tomorrow."		glucose testing. The SN	
	- 11	. F 2]		documented that the patient d	
	2 Clinical reco	rd number 3 included a		not comply with blood glucose testing and did exhibit s/s rela	
				to hypoglycemia. The SN faile	
	-	blished by the physician		document physician notificatio	
		ion period 3-22-16 to		the patient's reluctance to	
	5-20-16. The plan evidenced			perform blood glucose testing	.
	interventions to	address congestive heart		The physician has been notified	
	failure including	g daily weights. The plan		of the patient's noncompliance	
	-	to record weight daily		with blood glucose testing Thi	
		eight gain of 2 lbs in one		SN is no longer employed by	
	-			agency. All nursing staff have	
		ne week or as per		been educated regarding the	
	physician order.			requirement to notify the	

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Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 91 of 104

STATEME	INT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			PLETED
		157223	B. WING	<u></u>		0/2016
			QTD	EET ADDRESS, CITY, STATE, ZIP (_	
NAME OF	PROVIDER OR SUPPLIE	ER			LODE	
		H OF INDIANA, LLC		649 HIGHWAY 41 NORTH ANSVILLE, IN 47725		
				ANSVILLE, IN 47725		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAC			DATE
				physician of any change	-	
	A. A SN vis	sit note dated 4-6-16		patient's condition or r Clinical Record #8 (A-		
	identifies the pa	atient is unable to weigh		failed to document phy		
		orbid obesity" and "it		notification of improve		
	-	insafe for [the patient] to		patient's wound and w		
		e due to morbid obesity		no longer being neede		
		•		failed to document wo	und care	
	and living alone	e."		performed on the 5/13	/16 visit.	
				The wound care was r		
	B. The reco	ord failed to evidence the		discontinued and the		
	RN had inform	ed the physician of the		performed wound care		
	patient's inabili	ty to complete daily		as observed and docu	•	
	-	itor for fluid retention and		the SN. The physician notified of the	has been	
	-	toms of congestive heart		condition/improvemen	t of the	
	failure.	toms of congestive heart		wound. This SN has b		
	lallule.			educated regarding th		
				requirement of N546:	that agency	
		ord number 6 included a		professional staff mus		
	plan of care est	ablished by the physician		physician to any chang	-	
	for the certifica	tion period 3-31-16 to		patient's condition or r		
	5-29-16. The p	lan of care evidenced		failed to notify the phy RN that PT services w		
	-	address blood glucose		discontinued per patie		
		an states, "SN to perform		The physician has bee		
	· ·	liabetes: blood glucose		and the therapist educ		
		-		regarding the requiren		
	testing and eval	luation."		N546: that the physicia	an must	
				promptly be alerted to		
		notes, dated 4-6-16,		changes in the patient	'S	
	4-8-16, 4-13-16	5, 4-18-16, 4-27-16,		condition or needs.	vill bo	
	5-6-16, and 5-1	3-16 evidenced the patient		25% of all visit notes v reviewed weekly, begi		
	does not "check	k blood sugar regularly"		of 6/13/16, for complia		
		ient can tell by "how [the		RN or qualified therap		
	patient] feels."			the physician to change	-	
	patient reers.			patient's needs and co		
				a period of 6 weeks. T		
		nission Note Report"		90%. If Threshold of 9		
	dated 3-31-16 s	states, "Patient had fallen		achieved for 6 consec		
	OOB four of be	ed] and was noted to have		then chart audits can I	ре	

Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 92 of 104

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/20/2016	
NAME OF	PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZIP CODE				
VIAQUE	ST HOME HEALT	h of Indiana, llc			HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH	IOULD BE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
	a blood sugar i	n the 40's. New			decreased to 10% qua	-	
	compression fr			reviews. The Clinical			
					Director/designee will b responsible for monitor		
	C. The reco	ord failed to evidence the			corrective actions to er	-	
	RN had inform	ed the physician of the			this deficiency is corrected.	cted.	
	patient's relucta	ance to perform blood					
	sugar testing.						
	4. Clinical rec	ord number 8 included a					
	plan of care est	ablished by the physician					
	-	tion period 4-12-16 to					
	6-10-16. The p	blan of care states, "SN/CG	-				
	-	patient] to cleanse wound					
	bed with NS [n						
	using aseptic te	chnique. Using aseptic					
	technique apply	y Muprocin to wound bed,					
	cover with 4x4	gauze, wrap with Kerlix					
	and secure with	n tape."					
	A. A SN vi	sit note dated 5-13-16					
	notes "wound h	has covered over with scab					
	and no active d	rainage notes. Pt advised					
	that wound ma	y still be open some					
	underneath and	could open back up."					
	B. The reco	ord failed to evidence the					
	RN had inform	ed the physician of the					
	condition of the	e wound and that the					
	dressing chang	e was no longer needed.					
	C. The plan	of care included orders					
	-	erapy (PT) services 2 times					
		weeks. The record					
	-	lischarge note dated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care." N 0549 410 IAC 17-14-1(a)(1)(J) Scope of Services Bldg. 00 Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the followina: (J) Direct the activities of the licensed practical nurse. All clinical staff will be educated N 0549 06/19/2016 Based on record review and interview, on. the agency failed to ensure the registered ·The requirements of 410 IAC nurse (RN) had directed and supervised 17-14-1(a)(1)(J)-Scope of the licensed practical nurse (LPN) in 2 Services State Form Event ID: Facility ID: IN005940 If continuation sheet Page 94 of 104 EDWQ11

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	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u>00</u>	COMPLETED
	of conduction	157223	B. WING	00	05/20/2016
		137223			03/20/2010
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
VIAQUE	ST HOME HEALT	H OF INDIANA, LLC	EVAN	SVILLE, IN 47725	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	<u>`</u>	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	· · · · ·	2 records reviewed of		•The RN shall direct and	
	patients that rec	eived services from the		supervise the activities of the •Agency Policy C-300	
	LPN.			(Supervision)	
				A clinical record review of 25%	% of
	The findings in	clude:		active patients receiving nursi	ng
				services delivered by the LPN	will
	1 Clinical reco	ord number 8 included		be conducted to determine	
		sit notes, signed and dated		of N549: that the RN directs a	
		it failed to evidence		supervises the LPN and that t	
	-		-	record reflects communication	
	supervision of t	he LPN by the RN.		between the LPN and the RN	
				Clinical Record #8	
		l nurse visit note, signed		1.The record included a ver	
		e LPN, employee M, on		physician's order for medication	
	4-22-16, states,	"INR [blood test used to		changes and lab test that was signed/dated by the LPN and	
	monitor patient	s being treated with blood		reviewed and co-signed by the	e
	thinning medica	ations] 2.0 via fingerstick		RN. Supporting documentatio	
	method, pt [pati	ient] tolerated well and		attached.	
	without inciden	t and results called to		2.The clinical record contain	is a
	[name of physic	cian] and spoke with		communication note, dated	
	[name of office			5/10/16, between the LPN and RN, regarding the PT/INR that	
		perconner].		demonstrates communication	
	The record	d included a verbal		between the LPN and RN.	
		er for medication changes		Supporting documentation	
	1 2	U		attached.	
		bod test signed and dated		3.The clinical record contain	is a
	by employee M	on 4-20-10.		communication note, dated 5/17/16, between the LPN and	4
				RN, regarding the PT/INR that	
		l nurse visit note, signed		demonstrates communication	
	and dated by the	e LPN, employee M, on		between the LPN and RN.	
	5-9-16, states, "	PT/INR right middle		Supporting documentation	
	finger called to	[name of physician]."		attached.	
	The record failed to evidence any		4.The clinical record does		
		between the LPN and the		contain evidence of communication, as noted in A	-0
	RN.			between the LPN and RN	ς,
				regarding blood test results ar	nd

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

by the LPN, employee O, on 4-20-16. The note states, "spoke with patient and [spouse] about perhaps obtaining urine specimen for UA [urinalysis], I would speak with RN about the situation, explained the goal of nursing services is to not only educate disease process but if we can prevent another hospitalization, [spouse] verbalizes agreement, patient

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157223	B. WING		05/20/2016
		R H OF INDIANA, LLC	14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725	
				5VILLE, IN 47725	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)	IAG	the resulting medication char	
		d included a verbal		and supporting documentation	•
		er, signed and dated by		attached.	
	· ·	5-9-16 for the fingerstick		100% of all patient charts th	nat
	blood test on 5-	9-16.		are receiving LPN services w	vill be
				reviewed weekly,beginning	
	C. A skilled	nurse visit note, signed		6/13/16, to ensure that the R supervising the LPN appropr	
	and dated by the	e LPN, employee M, on		as required, for a period of 6	latery
	5-16-16, states,	"PT/INR right middle		weeks. Threshold is 95%. If	
	finger results ca	alled to [name of		Threshold of 95% is achieved	
	-	ne record failed to		consistently for 6 weeks then	
		ommunication between the		chart audits can be decrease	-
	LPN and the RN			to10% quarterly chart review The Clinical Director/designe	
				be responsible for monitoring	
	The record	d included a verbal		these corrective actions to er	
				that this deficiency is corrected	
		er, signed and dated by			
	1 5	5-10-16, for a medication			
	change and furt	her blood testing.			
		rd failed to evidence any			
		between the RN and the			
	LPN regarding	the blood test results and			
	the resulting me	edication changes.			
	2. Clinical reco	ord number 10 included a			
	skilled nurse vis	sit note signed and dated			
	1	-			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG stubbornly agrees that avoiding going back to hospital is in best interest." A. The record failed to evidence the RN had consulted with the LPN regarding the possibility of obtaining a urine specimen. The record failed to evidence any urinalysis results. B. The RN, employee K, stated, on 5-20-16 at 2:00 PM, "I spoke with the LPN. The [spouse] refused. It is not documented." 3. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 4. The agency's September 2013 "Supervision" policy and procedure number C-300 states, "Licensed Practical Nurse Supervision. ViaQuest shall provide Licensed Practical Nurse services under the direction and supervision of a Registered Professional Nurse when services are indicated and ordered by the physician." N 0559 410 IAC 17-14-1(a)(2)(G) Scope of Services Bldg. 00 Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLI	SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14649 HIGHWAY 41 NORTH IEALTH OF INDIANA, LLC EVANSVILLE, IN 47725				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C licensed practica	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	chiropractor, poor changes in the p after consulting w registered nurse Based on recor the agency faile practical nurse the registered m of 2 records rew received servic The findings in 1. Clinical reco skilled nurse vi by the LPN, that supervision of A. A skilled and dated by th 4-22-16, states, monitor patient thinning medic method, pt [pat without incider [name of physis [name of office The recor physician's ord	d review and interview, ed to ensure the licensed (LPN) had consulted with nurse (RN) in 2 (#s 8 & 10) viewed of patients that es from the LPN. clude: ord number 8 included sit notes, signed and dated at failed to evidence the LPN by the RN. d nurse visit note, signed te LPN, employee M, on , "INR [blood test used to as being treated with blood ations] 2.0 via fingerstick ient] tolerated well and at and results called to cian] and spoke with e personnel]."	N 0559	All clinical staff will be edu on: • The requirements of 41 17-14-1(a)(2)(G) • The LPN must consult with RN • Agency Policy C-300 (Supervision) A clinical record review of active patients receiving n services delivered by the L be conducted to determine compliance with the requir of N559: that the The LPN consult with the RN ClinicalRecord #8 1. The record included a physician's order for media changes and lab test that signed/dated by the LPN a reviewed and co-signed by RN. Supporting document attached. 2. The clinical record con communication note, date 5/10/16, between the LPN RN,regarding the PT/INR demonstrates communication attached. 3. The clinical record con communication note, date 5/17/16, between the LPN RN,regarding the PT/INR	0 IAC vith the 25% of ursing PN will ements must verbal cation was and y the ation tains a d and that tion	06/19/2016

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CON	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING <u>00</u> B. WING		00	COMPLETED 05/20/2016	
NAME OF		תי	ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	IK	14	4649 H	IGHWAY 41 NORTH		
VIAQUE	ST HOME HEALTH	H OF INDIANA, LLC	E	VANS\	/ILLE, IN 47725		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
					demonstrates communication		
	B. A skilled	l nurse visit note, signed			between the LPN and RN.		
	and dated by th	e LPN, employee M, on			Supporting documentation attached.		
	5-9-16, states, '	PT/INR right middle			4.The clinical record does		
		[name of physician]."			contain evidence of		
	•	ed to evidence any			communication, as noted in A-0	C,	
		between the LPN and the			between the LPN and RN		
	RN.	between the Er N and the			regarding blood test results and		
	IXIN.				the resulting medication change and supporting documentation		
					attached.	15	
		rd included a verbal			Clinical Record #10 (A-B) The	,	
		er, signed and dated by			RN failed to document		
	employee M on	5-9-16 for the fingerstick			communication between the RI	N	
	blood test on 5-	9-16.			and LPN or the refusal of the		
					patient's spouse in providing a		
	C. A skilled	l nurse visit note, signed			urine specimen and having a urinalysis. This RN was educated	bd	
	and dated by th	e LPN, employee M, on			regarding the requirements of	su	
		"PT/INR right middle			N559. In addition, all nursing st	aff	
		alled to [name of			will be educated regarding the		
	•	ne record failed to			requirements of N559 and the		
		ommunication between the			acceptable modes of		
	LPN and the RI				communication. 100% of all		
	LPN and the RI	N.			patient charts that are receiving LPN services will be reviewed		
					weekly, beginning 6/13/16, to		
		rd included a verbal			ensure that the RN is supervisi	ng	
	1 2	er, signed and dated by			the LPN appropriately as		
	1 2	5-10-16, for a medication			required, for a period of 6		
	change and furt	her blood testing.			weeks. Threshold is 95%. If Threshold of 95% is achieved		
					consistently for 6 weeks then		
	D. The reco	rd failed to evidence any			chart audits can be decreased	to	
	communication	between the RN and the			10% quarterly chart reviews.		
	LPN regarding	the blood test results and			The Clinical Director/designee	will	
	0 0	edication changes.			be responsible for monitoring		
					these corrective actions to ensu		
	2 Clinical read	ord number 10 included a			that this deficiency is corrected	•	
	skilled nurse vi	sit note signed and dated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 157223 B. WING 05/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14649 HIGHWAY 41 NORTH VIAQUEST HOME HEALTH OF INDIANA, LLC EVANSVILLE. IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG by the LPN, employee O, on 4-20-16. The note states, "spoke with patient and [spouse] about perhaps obtaining urine specimen for UA [urinalysis], I would speak with RN about the situation, explained the goal of nursing services is to not only educate disease process but if we can prevent another hospitalization, [spouse] verbalizes agreement, patient stubbornly agrees that avoiding going back to hospital is in best interest." A. The record failed to evidence the LPN had consulted with the RN regarding the possibility of obtaining a urine specimen. The record failed to evidence any urinalysis results. B. The RN, employee K, stated, on 5-20-16 at 2:00 PM, "I spoke with the LPN. The [spouse] refused. It is not documented." 3. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 4. The agency's September 2013 "Supervision" policy and procedure number C-300 states, "Licensed Practical Nurse Supervision. ViaQuest shall provide Licensed Practical Nurse services State Form Event ID: EDWQ11 Facility ID: IN005940 If continuation sheet Page 100 of 104

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 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 FORM APPROVED

 CENTERS FOR MEDICARE & MEDICAID SERVICES
 OMB NO. 0938-0391

 STATEMENT OF DEFICIENCIES
 X1) PROVIDER/SUPPLIER/CLIA
 X2) MULTIPLE CONSTRUCTION
 X3) DATE SURVEY

 AND PLAN OF CORRECTION
 IDENTIFICATION NUMBER:
 A. BUILDING
 00
 COMPLETED

 157223
 B. WING
 05/20/2016
 05/20/2016

		157223	B. WING	G		05/20/2016
	PROVIDER OR SUPPLI ST HOME HEALT	er 'H of Indiana, llc		14649 H	ddress, city, state, zip code IGHWAY 41 NORTH /ILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY O under the direc Registered Pro	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) tion and supervision of a fessional Nurse when dicated and ordered by the		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
N 0596 Bldg. 00	shall be response to patient contact furnish home here behalf meet the as follows: (1) The home here (A) have succest competency eva- addresses each subsection (h) of Based on record the agency fail competency eva- the required su home health ail The findings in 1. Personnel fi- individual had provide home to behalf of the age competency eva- provided to the competency eva- sponge, tub, or	es) The home health agency sible for ensuring that, prior et, the individuals who alth aide services on its requirements of this section health aide shall: essfully completed a aluation program that of the subjects listed in f this rule; and ed review and interview, ed to ensure the valuation addressed all of bject areas in 1 (file I) of 2 de files reviewed.	N 059	96	Agency staff will be educated of the following: •The requirements of 410 IA0 17-14-1(I)(A) Scope of Service •Review of the specific requir content of the home health aid competency evaluation •Agency Policy C-220 (Aide Services) A review of the personnel rec of all home health aides employed by this agency will b conducted to ensure compliand with N596: that the home healt aide competency evaluation addresses all subject matter required. Any areas of noncompliance identified will result in a reassessment of the home health aide's competence by an outside agency. In	C s red e ord e ce h

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157223	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/20/2016
	PROVIDER OR SUPPLIE ST HOME HEALTI	R H OF INDIANA, LLC	14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725	
(X4) ID PREFIX TAG	(EACH DEFICIE	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-REFRENCED TO THE APPROPRIAT DEFICIENCY)	re (X5) COMPLETIC DATE
V 0602 Bldg. 00	techniques (410 toileting and eli 17-14-1(h)(9)(F recording temp respiration (410 2. The Clinical 5-20-16 at 4:00 evaluation prov address all of th 3. The agency' Services'' polic C-220 (C) state providing aide through training evaluations.'' 410 IAC 17-14-1 Scope of Service Rule 14 Sec. 1(n shall be assigned	 (m) (m) (IAC 17-14-1(h)(10)), imination (410 IAC (a) (AC 17), and reading and erature, pulse, and (b) (AC 17-14-1(h)(3)). (a) Director indicated, on PM, the competency rided to employee I did not the required subject areas. (b) August 2013 "Aide y and procedure number s, "All individuals services will be qualified g and/or competency (m) 		personnel file I, the home heal aide was hired on 2/24/16 and competency was evaluated on 3/3/16 and 3/4/16 using the incorrect form. The information was placed on the correct form provided by the Indiana Association for Home and Hospice Care, that contains all the subjects required by N596. However, the incorrect form wa left in the personnel file, along with an additional competency assessment performed to mee the requirements of the Home Health Aide Registry. Therefor there appeared to be discrepancies related to the competency evaluation. Goin forward, the agency will only utilize the IAHHC aide competency evaluation to evaluate competency of home health aides (once the 2 year preclusion is lifted). 100% of newly hired home health aide personnel files will be audited the competency evaluation addresses all of the required subject areas. Compliance threshold is 100%. The Clinic Director/designee will be responsible for monitoring thes corrective actions to ensure that this deficiency is corrected.	th h h h h h h h h h h h h h

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	Image: RS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 157223		(X2) MULTIPLE C A. BUILDING B. WING	00	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/20/2016	
	PROVIDER OR SUPPLIE	r † of Indiana, llc	14649	address, city, state, zip code HIGHWAY 41 NORTH SVILLE, IN 47725		
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	(X5) COMPLETION DATE	
	the agency failed instructions had home health aid reviewed of pat health aide serv The findings ind 1. Clinical reco plan of care esta for the certifica 5-29-16. The p orders for home time per week f evidenced the h had been provid record failed to nurse (RN) had instructions for services to be p 2. Employee L person, stated, o "There is no aid the RN in the co 3. The agency's Plan" policy and C-751 (C) state appropriate Car to be performed	clude: ord number 6 included a ablished by the physician tion period 3-31-16 to lan of care included e health aide services 1 For 8 weeks. The record some health aide services ded 1 time per week. The evidence the registered prepared written the home health aide rovided. , the software support on 5-19-16 at 2:35 PM, le assignment sheet per	N 0602	All clinical staff will be educate on the following: •The requirements of 410 IA 17-14-1(m) Scope of Services •The home health aide must assigned to a particular patier an RN or therapist; Written patient care instructions for th home health aide must be prepared by the RN or other appropriate professional who responsible for the supervision the home health aide. •Agency Policy C-751 (Aide Care Plan) A clinical record review of 25 active clinical records of patie receiving home health aide services will be reviewed to ensure that written patient car instructions for the home heal aide are present as required to N602. Clinical Record #6 Th RN did fail to prepare written instructions for the home heal aide services to be provided. Written instructions for the home heal aide services to be provided. Written instructions for the home heal aide services to be provided. Written instructions for the home health aide have now been prepared and are present in th clinical record. This RN is no longer employed with this age 100% of all patient charts th are receiving aide services wi reviewed every two weeks, beginning week of 6/13/16, fo compliance that each patient record shows evidence of writt patient care instructions for th home health aide are prepare the RN, for a period of 2 mont Threshold is 90%. If Thresho	AC s t be t be t by e is n of 5% nts re th Dy th th Dy th th th Dy th th Dy th th th th th th th th th th	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X							PRINTED: 06/17/2016 FORM APPROVED OMB NO. 0938-0391	
	OF CORRECTION	IDENTIFICATION NUMBER: 157223	A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/20/2016			
	PROVIDER OR SUPPLIEF	OF INDIANA, LLC		14649 H	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 41 NORTH VILLE, IN 47725			
(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) COMPLET DATE	ION
	Therapist."				90% is achieved consistently months then chart audits can decreased to 10% quarterly c reviews. The Clinical Director/designee will be responsible for monitoring the corrective actions to ensure th this deficiency is corrected.	be hart se		