	T OF HEALTH AND HU R MEDICARE & MEDI				FORM APPROVE OMB NO. 0938-03	
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/20/2015	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ARDER CT STE B	•	
ASSURE	ED HOME HEALTH	ICARE INC		RERVILLE, IN 46375		
(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) COMPLETIC DATE	ON
G 000		,				
Bldg. 00	recertification s 2-3-2015 to 2-1 Survey Dates: 3 Facility #: 0111 Medicaid Vend Surveyor: Tamo PHNS Four conditions were found to b standards were	3-19-15 and 3-20-15 21 or#: 200839240 eka Warren, RN, BSN, and sixteen standards be corrected and two recited during this survey. T Joyce Elder, MSN,	G 000			
G 121 Bldg. 00	accepted profess	- STD staff must comply with sional standards and ply to professionals	G 121	The Administrator a Director of Nursinga		)15
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

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

PRINTED: 04/14/2015

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.

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	/	E SURVEY
IND PLAN	OF CORRECTION	157581	A. BUILDING <u>00</u> B. WING			COMPLETED 03/20/2015	
JAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	<b>I</b>	
ASSURE	ED HOME HEALTH	ICARE INC			RERVILLE, IN 46375		
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 I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	<ul> <li>Based on observer review of policy agency failed to services in accorrect infection control visit observation the potential to for employee A Findings:</li> <li>1. Home visit of 3/20/15 at 9:15 employee A, Rewas observed p patient's ottoma RN placed a perpatient's table a without barrier. patient's floor w</li> <li>2. Interview with nursing (DON) Assurance (QA 3/20/15 at 12:10 employee A, rehave used a barriequipment durit #4's home.</li> <li>3. The agency's</li> </ul>	vation, interview, and y and procedures, the o ensure staff had provided ordance to their own of polices in 1 of 1 home in with patient #4 creating affect any patients cared A. bservation made on AM to patient #4, with egistered Nurse. The RN lacing nursing bag on an without barrier. The rsonal binder on top of ind personal items (Bible) The RN placed a coat on vithout a barrier. th employee C, director of and employee B, Quality ) registered nurse, on D PM indicated that gistered nurse, should rier for bag and ing home visit to patient		TAG	Quality Assurance Nurse have review the standard, 484.12(c), Compliancewith Accepted Profession Standards and Principles, and age policy on BagTechnique. The Administrator, Director of Nursing, and Quality Assurance Nurse h also discussed with employee A individuallyabout th home visit findings and observations, reviewing the standards andprinciples with agency policy. Employee A has verbalized	onal ncy ty ave n he	DATE
		ted May 2010, states,			verbanzed		

PPG012 Facility ID: 011121

If continuation sheet Page 2 of 12

Event ID:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 03/20/2015	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
ASSURE	ASSURED HOME HEALTHCARE INC			RERVILLE, IN 46375		
(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 F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	"Purpose: To de maintaining a c preventing cross When the visit : equipment will soap and water, solution, hands	escribe the procedure for lean nursing bag and s contamination 5. is completed, reusable be cleaned using alcohol, or other appropriate will be washed, and supplies will be returned		understanding as EmployeeA was shown a video on proper bag techniq and was also shown demonstration of ba technique by the Director of Nursing and Employee A ha also performeda re- demonstration duri the discussion. The Director of Nursing also supervised ahome with Employee A observing proper b technique in a patie homeon 4/6/15, and has been observed use proper bag technique with use properbarriers for nursing bag and equipment used for	ue, n a ag g, as turn ng visit ag ent's d to of	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 03/20/2015
	ROVIDER OR SUPPLIE		1947 <b>⊢</b>	ADDRESS, CITY, STATE, ZIP CODE IARDER CT STE B RERVILLE, IN 46375	-
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPF	E COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	patient care during the visit.	DATE
				The Director of	
				Nursing and QualityAssurance	
				Nurse will further in-service field staf	for
				April 17, 2015,	
				goingover and reviewing the stand	lard
				and bag technique	with
				return demonstration by all staff on an	on
				individual basis.	
				The Administrator, Director of	
				Nursing, and Qualit	у
				Assurance Nurse w be responsible for t	
				maintenance	
				andmonitoring the compliance in	
				accordance with	
				policies and proceduresimpleme	ente

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	, í	JILDING	NSTRUCTION <u>00</u>	(X3) DATE COMPL 03/20/	LETED
	PROVIDER OR SUPPLIE			1947 HA	ADRESS, CITY, STATE, ZIP CODE ARDER CT STE B ERVILLE, IN 46375		
(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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
G 158 Bldg. 00	484.18 ACCEPTANCE C SUPER Care follows a w	DF PATIENTS, POC, MED ritten plan of care periodically reviewed by a			d for control of communicable diseas by requiring field employeesperform a yearly return demonstration individually of bag technique observingstandard precautions.	5e	
	medicine. Based on observence review and intervence ensure the plan followed by the providing servence record reviewed Findings: 1. Home visit o	e, osteopathy, or podiatric vation, clinical record rview, the agency failed to of care (POC) was registered nurse ces for 2 of 4 clinical d (#1 and 4). bservation made on AM to patient #4, with	G 1.	58	The Administrator, Director of Nursing, and Quality Assurance Nurse have reviewed the standard, 484.18, Acceptance ofPatients, Plan of Care, and Medical Supervision that care follows a writtenplan of care established and periodically reviewed by a doctor of medicine, osteopathy, podiatric medicine. TheAdministrator, Director of Nursing, and Qualit Assurance Nurse have furtherdiscussed with employe individually who was directly associated with the clinicalrect findings and home visit during revisit survey reviewing the	y e A ord	04/17/201

	R MEDICARE & MEDIC NT OF DEFICIENCIES			CONCERNICEION		IB NO. 093
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE COMPI	
AND I LAN	OF CORRECTION	157581	B. WING	00	03/20	
		137381			03/20	/2013
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
	ED HOME HEALTH	CARE INC		RERVILLE, IN 46375		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPL
TAG		R LSC IDENTIFYING INFORMATION)	TAG	standardto ensure this deficie		DAT
		gistered nurse. During		may not recur with the emplo	•	
	this visit the pat	tient's feet were not		as care services of the agence	-	
	assessed.			to be provided in accordance		
				the patient's plan of carethat		
	A Inter	rview on 3/20/15 at 10:15		established and reviewed by physician. After discussion		
				Employee A,clinical notes aff		
	-	registered nurse, has never touched or reviewed and Em		the re-visit survey have been		
	-			reviewed and Employee A		
	checked the fee	t during any visits.		hasdocumented appropriatel		
				reflect the patient's plan of ca assessment offeet and foot of		
	B. Clin	ical Record #4 (SOC		see Addendum 1. Review of	•	
		ation Period 3/7/15-		patient's vital sign		
				parameterswere reviewed, a	nd	
	<i>2</i> · ·	d a plan of care that		Employee A informed the		
	states, " SN [	skilled nurse] is to assess		physician on 3/21/2015 notifyingphysician of the patie	ent's	
	pt.'s [patient's] p	physical and mental status		increased heart rate as	0.11.0	
	SN to assess/	instruct on diabetic		documented by acommunica		
		include: nail, skin & foot		note, see Addendum 2. The		
	care"	menade. man, sam & 1000		Administrator, Director of Nursing,and Quality Assuran	<u></u>	
				Nurse will further in-service	UC	
				agency staff on April 17,2015	5 that	
	C. Inter	view on 3/20/2015 at		care services are to follow a		
	12:35 PM, emp	loyee C, administrator,		written plan of care		
	employee D, the	e director of nursing,		established,reviewed, and signature by a physician in accordance		
		oyee B, quality assurance		the standard. TheQuality	,	
				Assurance Nurse will audit 1	0%	
	registered nurse	, agreed patient #4's feet		of clinical records quarterly		

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

should have been assessed at this home

visit observation and at all previous

skilled nursing visits with patient #4.

2. Clinical record # 1, start of care

12/13/14, included a POC for the

certification period of 2/11/15 - 4/11/15

Event ID:

PPG012

Facility ID: 011121

maintained.

through02-2016 for compliance and to monitor these corrective

actions, to ensure thisdeficiency

is corrected and will not recur. All findings will be reported to he Director of Nursing and is

responsible that this deficiency is

correctedand compliance

If continuation sheet

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04/14/2015

PRINTED:

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157581	B. WING		03/20/2015	
			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER	1947 H	ARDER CT STE B		
ASSURE	D HOME HEALTH	ICARE INC	SCHER			
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
ind		SN to inform physician if	1/10		DATE	
		heart rate greater than				
		n 60 beats/min"				
	A. Ho	me visit observation made				
	on 3/20/15 at 9	:00 AM to patient #1 with				
	Employee A, re	egistered nurse. During				
	this visit the pa	tient's heart rate was				
	observed being	110. The record failed to				
	evidence the ph	sysician was informed of				
	the out of range	the out of range heart rate.				
		w on 3/20/15 at 12:35 PM				
		C, administrator,				
		ON, and employee B, QA				
	-	e, each agreed the				
		e, employee A, should and inform the physician				
		out of range heart rate of				
		ig home visit observation.				
	-	dministrator, stated she				
		e physician of the elevated				
	out of range hea	art rate.				
٥٥٥ ٧						
Bldg. 00			N 000			
	This was a revi	sit survey for the State				
		vey conducted on				
	2-3-2015 to 2-1	-				
	2-3-2013 10 2-1	0-2013.	1			

	R MEDICARE & MEDIC				OMB NO. (	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVE COMPLETED 03/20/2015	Y
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE	•	
ASSURE	D HOME HEALTH	CARE INC		HARDER CT STE B ERERVILLE, IN 46375		
(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	COM	PLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	D	ATE
	-	-19-15 and 3-20-15				
	Facility #: 0111	21				
	Medicaid Vende	or#: 200839240				
	Surveyor: Tame PHNS	ka Warren, RN, BSN,				
	-	es were found corrected ncies were recited during				
	Quality Review BSN, RN April 1	: Joyce Elder, MSN,				
N 470 Bldg. 00	shall be written a control of commu compliance with a laws. Based on observe review of policy agency failed to services in accoor infection control visit observation	ncy	N 470	The Administrator and Director Nursingand Quality Assurance Nurse have reviewed the rule 410 IAC 7-12-1(m), Home He agencyadministration/ management that policies and procedures shall be written andimplemented for the contr communicable diseases in compliance withapplicable fee	e alth I ol of	7/201
fe F	for employee A Findings:			and state laws, and also reviewing agencypolicy on Ba Technique. The Administrator Director of Nursing,and Qualit Assurance Nurse have also	g	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTE

	Г OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-0391	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157581		A. BUILDING B. WING	00	COMPLETED 03/20/2015	
	NAME OF PROVIDER OR SUPPLIER ASSURED HOME HEALTHCARE INC			ADDRESS, CITY, STATE, ZIP CODE ARDER CT STE B RERVILLE, IN 46375		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) discussed with employee A	(X5) COMPLETION DATE	
	employee A, Reg was observed pla patient's ottomar RN placed a per- patient's table an	gistered Nurse. The RN acing nursing bag on a without barrier. The sonal binder on top of d personal items (Bible) The RN placed a coat on		individuallyabout the home vis findings and observations, reviewing the standards andprinciples with agency poli Employee A has verbalized understanding as EmployeeA was shown a video on proper technique, and was also show demonstrationof bag techniqu the Director of Nursing, and Employee A has also perform	icy. bag /n a e by eda	
	nursing (DON) a Assurance (QA) 3/20/15 at 12:10 employee A, reg have used a barr	n employee C, director of and employee B, Quality registered nurse, on PM indicated that istered nurse, should ier for bag and g home visit to patient		return demonstration during the discussion. The Director of Nursing also supervised ahom visit with Employee A observing proper bag technique in a patient's homeon 4/6/15, and been observed to use proper technique with use of properbarriers for nursing bag and equipment used for patient care during thevisit. The Direct of Nursing and QualityAssurant Nurse will further in-service file etaff on April 2, 2015. gained	ne ng has bag nt ector nce eld	
	3 The agency's	policy titled "Bag		staff on April 17, 2015, goingo	iver	

3. The agency's policy titled "Bag Technique", dated May 2010, states, "Purpose: To describe the procedure for maintaining a clean nursing bag and preventing cross contamination ... 5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to bag ... ."

technique with return demonstration by allstaff on an individual basis. The Administrator, Director of Nursing, and Quality Assurance Nurse will be responsible for the maintenance and monitoring the compliance in accordance with policies and proceduresimplemented for control of communicable disease by requiring field employeesperform a yearly return demonstration individually of bag technique observingstandard

and reviewing the rule and bag

State Form

Event ID: **PPG012** Facility ID: 011121 If continuation sheet

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04/14/2015

	R MEDICARE & MEDI						B NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII B. WIN		00	COMPL	
		157581	D. WIN	<u> </u>		03/20/	2015
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					IARDER CT STE B		
ASSURE	D HOME HEALTH	ICARE INC		SCHEF	RERVILLE, IN 46375		
(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 APPROPRIAT	E	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					precautions.		
522	410 IAC 17-13-1	(a)					
	Patient Care	(~)					
Bldg. 00		) Medical care shall follow					
-		plan of care established					
		reviewed by the physician,					
	podiatrist, as follo	ctor, optometrist or					
		5w5.	N 52	2	The Administrator, Director of		04/17/2015
			11 32.	2	Nursing, and Quality Assurance		07/1//2012
	Deced on obcom	vation, clinical record			Nurse have reviewed the Rule,		
		,			410 IAC 17-13-1(a), Patient		
		rview, the agency failed to			Care, that medical care shall follow a written medical plan of		
	-	of care (POC) was			care established andperiodical		
		registered nurse			reviewed by the physician,	y	
		ces for 2 of 4 clinical			dentist, chiropractor, optometris	st,	
	record reviewed	d (#1 and 4).			orpodiatrist. The Administrator,		
					Director of Nursing, and Quality Assurance Nurse have further		
	Findings:				discussed with Employee A		
					individuallywho was directly		
	1. Home visit of	bservation made on			associated with the clinical reco	ord	
	3/20/15 at 9.00	AM to patient #4, with			findings and home visitduring the	ne	
		•			revisit survey reviewing the		
	~ -	gistered nurse. During			standard to ensure this deficier maynot recur with the employe	-	
	this visit the par	tient's feet were not			as care services of the agency	-	
	assessed.				are to be providedin accordance	e	
					with the patient's plan of care the		
	A Inte	rview on 3/20/15 at 10:15			is established and reviewedby		
					physician. After discussion with Employee A,clinical notes after		
		stated, "[employee A],			the revisit survey have been		
	registered nurse	e, has never touched or			reviewed and Employee A		
	checked the fee	t during any visits.			hasdocumented appropriately t		
					reflect the patient's plan of care		
	R Clin	ical Record #4 (SOC			assessment offeet and foot car see Addendum 1. Review of	e,	
					patient's vital sign		
	3/7/15, Certifica	ation Period 3/7/15-			parameterswere reviewed, and		

Event ID: PPG012 Facility ID: 011121

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		с ́	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING <u>00</u> B. WING		COMPLETED 03/20/2015	
NAME OF	PROVIDER OR SUPPLIE	R	STREET			
ASSUR	ED HOME HEALTH	ICARE INC		IARDER CT STE B RERVILLE, IN 46375		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
IAU	5/5/15), include states, " SN [ pt.'s [patient's] j SN to assess/ management to care" C. Inte 12:35 PM, emp employee D, th DON, and emp registered nurse should have bee visit observatio skilled nursing 2. Clinical reco 12/13/14, include certification per that stated, " symptomatic 100 or less than A. Hot on 3/20/15 at 92 Employee A, ret this visit the par observed being	ed a plan of care that skilled nurse] is to assess obysical and mental status finstruct on diabetic include: nail, skin & foot rview on 3/20/2015 at loyee C, administrator, e director of nursing, loyee B, quality assurance e, agreed patient #4's feet en assessed at this home n and at all previous visits with patient #4. rd # 1, start of care ded a POC for the fied of 2/11/15 - 4/11/15 SN to inform physician if heart rate greater than a 60 beats/min" me visit observation made 00 AM to patient #1 with gistered nurse. During tient's heart rate was 110. The record failed to ysician was informed of		Employee A informed the physician on 3/21/2015 notifyingphysician of the pa- increased heart rate as documented by acommunic note, see Addendum 2. Th Administrator, Director of Nursing, and Quality Assura Nurse will further in-service agency staff on April 17,20° care services are to follow a written plan of care established, reviewed, and s by a physician in accordance the standard. TheQuality Assurance Nurse will audit of clinical records quarterly through02-2016 for complia and to monitor these correct actions, to ensure thisdefici is corrected and will not rect findings will be reported tot! Director of Nursing and is responsible that this deficie correctedand compliance maintained.	tient's eation e nce 15 that a signed e with 10% nce tive ency ur. All ne	

If continuation sheet Page 11 of 12

PRINTED: 04/14/2015 FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391	
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	
		157581	B. WING		03/20/2015	
	PROVIDER OR SUPPLIE		1947 H	ADDRESS, CITY, STATE, ZIP CODE IARDER CT STE B RERVILLE, IN 46375		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	registered nurse registered nurse follow the POC of the elevated of patient #1 durin Employee C, ad	DN, and employee B, QA , each agreed the , employee A, should and inform the physician out of range heart rate of g home visit observation. ministrator, stated she e physician of the elevated				

State Form