	R MEDICARE & MEDI			DI E CONSTDUCTION		OMB NO. 0938-0391			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTII A. BUILDIN B. WING	ple construction G	CO	ATE SURVEY MPLETED (12/2012			
NAME OF	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 1947 HARDER CT STE B						
ASSURE	D HOME HEALTH	ICARE INC		CHERERVILLE, IN 46375					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	) PROVIDER'S PLAN OF	CORRECTION	(X5)			
PREFIX		NCY MUST BE PERCEDED BY FULL	PREF	CROSS-REFERENCED TO T		COMPLETION			
TAG G0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	G DEFICIENC:	1)	DATE			
			G0000	)					
	This visit was f	or a home health federal							
		survey. This was a partial							
	extended survey								
	Survey date: January 9 - 12, 2012								
	Facility #: 0111	21							
	Medicaid vendo	or #: 200839240							
	Surveyor: Ingr	id Miller, PHNS, RN							
	Skilled undupli	cated census: 153							
	Quality Review	r: Joyce Elder, MSN, BSN,							
	RN								
	Jar	nuary 17, 2012							

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

TITLE

(X6) DATE

PRINTED:

02/06/2012

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 OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/12/2012	
	PROVIDER OR SUPPLIE		STREET 1947 H SCHE	-		
(X4) ID PREFIX TAG G0121	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) S staff must comply with	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD D CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	<ul> <li>accepted profess principles that ag furnishing servic Based on person and policy revie ensure that 1 of annual evaluation policy. (file A)</li> <li>Findings <ol> <li>Personnel fi failed to evidend evaluation.</li> <li>On 1/12/12 aindicated the an been completed</li> <li>The agency Evaluation" witt "A competency- evaluation will be</li> </ol> </li> </ul>	sional standards and oply to professionals es in an HHA. mel file review, interview, tw, the agency failed to 1 administrator had an on as required by agency le A, date of hire 6/12/06, ce an annual performance at 3 PM, the administrator nual evaluation had not per agency policy. policy titled "Performance h no effective date states, -based performance be conducted for all 1 year of employment and	G0121	Performance evaluation wa immediately done on employ personnel file A by member board of directors January 7 2012. See Attachment A. Administrator in-serviced hu resources in updating employee records current. 100% of employee files will be audite yearly for evidence that a performance evaluation is completed. Administrator is responsible for monitoring compliance in the conduction annual performance evalua and ensure that this deficient corrected and will not recurred	yee of of the 13, iman byee ed ed in of tions ncy is	01/13/2012

Facility ID: 011121

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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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE G0158 Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric G0158 medicine. The administrator will in-service 02/06/2012 nursing staff that all provided Based on clinical record and policy services follows a written order review, and interview, the agency failed to signed by a physician. ensure skilled nurse services were Reinforcement will be given to the staff that all skilled nursing provided as ordered on the plan of care for services should be provided in 3 of 12 records (Clinical record #2, 3, and accordance to the written plan of 11) with the potential to effect all of the care (POC) or written physician patients of the agency. order. Administrator informed staff that any changes in the POC need to be reviewed and signed Findings by the physician. Complete date 2/6/12. Clinical record #2, 1. Clinical record #2, start of care (SOC) administrator discussed with employee D regarding visit on 12/20/11, included a plan of care with a 1/4/12 about the BP over the certification period of 12/20/11 - 2/17/12. ordered parameter as written in Care failed to follow the written plan of the POC. Employee D reports care (POC) as evidenced by the following: that they did inform the physician but failed to document communication. Narrative a. The clinical record document titled addendum for that visit was "Skilled Nursing Assessment" signed by added to clinical record. See Employee D, a registered nurse (RN), on Attachment B. Clinical record #3, 1/4/12, stated under vital signs, "BP administrator reviewed with Employee I the importance of [Blood Pressure] sitting 172/82." On measuring wounds and page 2 of this skilled nursing assessment accurately documenting the under cardiovascular -- SN [Skilled assessment of length, width, and Nurse] instructed pt/cg [patient/caregiver] depth. Clinical record #11, administrator provided education on: BP rechecked: 156/80. to nursing staff regarding all skilled nursing services must b. The POC states, "SN to inform the follow the written POC as ordered physician if the SBP [systolic blood by the physician. Administrator also reviewed policy and pressure] is greater than 160 mmHg procedures with Employee H and [millimeters of mercury]."

911 Facility

Facility ID: 011121

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	Ì.	JILDING	00 00	сом 01/1	TE SURVEY IPLETED 1 <b>2/2012</b>
	PROVIDER OR SUPPLIE			1947 H	ADDRESS, CITY, STATE, ZIP COE IARDER CT STE B RERVILLE IN 46375	DE	
ASSUR (X4) ID PREFIX TAG	<ul> <li>(EACH DEFICIE REGULATORY O</li> <li>c. On 1/11, administrator in pressure reading of 160 mmHg at the physician as</li> <li>2. Clinical rec included a plan periods of 10/14 12/14/11 - 2/10 assessment com Registered Nura the patient had left buttocks ind wounds at sites description lack length, width an a. The plan by Employees A on 10/14/11 for 10/14/11 - 12/1</li> <li>"Orders for Dis (Specify amour Skilled nursing physical and maginal b. On 1/11</li> </ul>	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) /12 at 3:20 PM, the indicated the systolic blood g was over the parameter and was to be called in to s ordered on the POC. ord #3, SOC 10/14/11, of care for certification 4/11 - 12/12/11 and /12. The recertification ipleted by Employee I, se, on 12/8/11 identified 2 wounds. The area on the dicated two pressure A and B. The wound and measurements of the and depth of these wounds.			RERVILLE, IN 46375	TLD BE ROPRIATE the POC gned by rying out s. In at all ncluded d care a 10% of dited ces in written d POC. or of ole for ding the onsible ective s	(X5) COMPLETIC DATE

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	NSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING 00			COMPLETED 01/12/2012	
		107001	B. W	-			
NAME OF	PROVIDER OR SUPPLIE	ËR			ADDRESS, CITY, STATE, ZIP CO	DDE	
ASSURE	ED HOME HEALTH	ICARE INC			ARDER CT STE B ERVILLE, IN 46375		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ord #11, SOC 9/20/11,					
	included a plan	of care for the					
	certification per	riod of 9/30/11 - 11/28/11,					
	failed to eviden	ce an accurate POC as					
	evidenced by th	e following documents					
	and interview:	The POC failed to					
	evidence an ord	ler for wound care or					
	medicated pow	der. This POC was signed					
	-	dated by Employees C and					
	H, RNs.	interior in the second se					
	,						
	a. The initi	al and assessment					
	document titled	"Outcome and					
	Assessment Inf	formation Set (Oasis-C)					
		ersion" with a date of					
		ned by Employee H stated,					
	-	Status: Surgical Wounds					
		ker implementation. This					
		cribed to be in the trunk					
		wound, length 5 cm, no					
		sing, attached edges,					
		ding tissue, dressing type					
		ew evaluation." At the					
		ssment, a narrative stated,					
		rding limitations to left					
	shoulder and w	ound care dressings."					
	b. A clinic	al document dated 10/4/11					
		Jursing Assessment -					
		ned by patient #11 and					
	-	N, under patient caregiver					
		ed, "Wound care done."					
		nd section of this					
	assessment, the	nurse stated, "Site left					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157581	B. WING		- 01/12/2012
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	DE
ASSURE	ED HOME HEALTH	ICARE INC	1947 H SCHEF		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	chest, Cleansed	with normal saline,			
	covered with no	on-adherent dressing, and			
	secured with ta	-			
	D. A clinic	cal document titled			
		f Care following Inpatient			
	-	13/11 and signed by			
		ated, "Teachings regarding			
	1 2	h small excoriated area			
	-	ast note of apply medicated			
	powder after ba	uning."			
		1/11 at 3:50 PM, the			
		ndicated no wound care or			
	application of r	nedicated powder were			
	included on the	POC.			
		policy titled Patient Plan of			
	Care with no ef	fective date stated, "The			
	plan of care sho	ould be developed,			
	implemented, a	nd revised in coordination			
	with the patient	, the physician, and the			
		y team members involved			
	-	care, in accordance with			
	-	urds of practice."			
	accepted station				

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number: 157581	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUC	CTION	(X3) DATE SURVEY COMPLETED 01/12/2012		
	ROVIDER OR SUPPLIE		1	947 HARDE				
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES	I PRI	ID PROVIDER'S PL/ PREFIX CEACH CORRECTIVE TAG DEFIC		BE	(X5) COMPLETIO	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE	
			1				1	

#### 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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG G0159 The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of G0159 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. The administrator will in-service 02/06/2012 nursing staff that all provided Based on clinical record and policy services follows the written review and interview, the agency failed to medical POC. Reinforcement will ensure current medications and treatments be given to the staff that all skilled nursing services should be were listed on the plan of care for 2 of 12 provided in accordance to the clinical records reviewed (Clinical record written plan of care (POC) or #1 and #11) with the potential to effect all written physician order. the patients of the agency. Administrator informed staff that any new orders, especially all patient medications, need to be Findings include updated in the written POC and signed by the physician. 1. Clinical record #1, start of care (SOC) Complete date 2/6/12. Clinical 6/13/11 and certification period 12/10/11 record #1. on 1/13/12 an addendum order for correction on - 2/7/12, failed to evidence an accurate the POC was written to include plan of care (POC) as noted by the the new medications on the plan following documents and interview: of care as ordered. See attachment C. Clinical record #11, administrator provided A. A physician's order signed by education to nursing staff Employee C, Registered Nurse (RN) and regarding all skilled nursing dated 12/7/11 stated, "Order: PLS [please] services must follow the written confirm: recertification dates from POC as ordered by the physician. Administrator also 12/10/11 - 2/7/12. Continue SN [skilled reviewed policy and procedures nurse] and HHA [Home health aide ] visit with Employee H and staff that diet medication and treatment ... New any changes in the POC must be meds [medications]: Colchicine 0.6 mg reviewed and signed by the

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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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG physician prior to carrying out any [milligram] tab [tablet] every 2 hrs nursing interventions. In [hours] po [by mouth] prn [as needed] for addition, emphasized that all pain, hydrocodone/apap [acetaminophen] medications need to be included 100/650 mg tab every 6 hrs po prn for in the POC. 10% of all clinical records will be audited quarterly pain." for evidence that the medical plan of care include all pertinent B. A clinical record document titled patient information especially all "Home Health Certification and Plan of current medications. Administrator and Director of Treatment with a certification period of nursing is responsible for 12/10/11 - 2/7/12 and signed by monitoring and educating the Employees C and E, RNs, on 12/10/11, staff in updating the POC and failed to evidence colchicine or maintaining adherence to policies regarding the patient POC to hydrocodone/apap. ensure this deficiency is corrected and will nor reoccur. C. On 1/11/12 at 3:15 PM the administrator indicated the colchicine and hydrocodone/APAP were not included on the plan of care. 2. Clinical record #11, SOC 9/20/11 with a certification period of 9/30/11 -11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview: A. The POC with a certification period of 9/30/11 - 11/28/11 failed to evidence an order for medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. B. On 1/11/11 at 3:50 PM, the administrator indicated no medicated powder was included on the POC. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TRZ911 Facility ID: 011121 If continuation sheet Page 9 of 53

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NTERS FOR MEDICARE & MEDICAID SERVICES			(	FORM APPROVE OMB NO. 0938-03			
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	ILDING	NSTRUCTION 00	(X3) DA COM	TE SURVEY IPLETED 12/2012	
NAME OF	PROVIDER OR SUPPLIEF	ξ		DDRESS, CITY, STATE, ZI	P CODE		
ASSUR	ED HOME HEALTH	CARE INC	1947 HA SCHER				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
	Description: Ski effective or revis and Responsibili- visits, performs evaluates patient with physicians	locument titled "Job lled Nurse" with no sion date stated, "Duties ities Makes home physical assessments, t's needs and consults if necessary to develop documents appropriately nanner."					

#### 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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE G0170 The HHA furnishes skilled nursing services in accordance with the plan of care. G0170 The administrator will in-service Based on clinical record and policy 02/06/2012 nursing staff that all provided review, and interview, the agency failed to services follows a written order ensure skilled services were provided as signed by a physician. ordered on the plan of care for 3 of 12 Reinforcement will be given to the staff that all skilled nursing records (Clinical record #2, 3, and 11) services should be provided in with the potential to effect all of the accordance to the written plan of patients of the agency. care (POC) or written physician order. Administrator informed staff that any changes in the POC Findings need to be reviewed and signed by the physician. Complete date 1. Clinical record #2, start of care (SOC) 2/6/12. Clinical record #2. 12/20/11, included a plan of care with a administrator discussed with employee D regarding visit on certification period of 12/20/11 - 2/17/12. 1/4/12 about the BP over the Care failed to follow the written plan of ordered parameter as written in care (POC) as evidenced by the following: the POC. Employee D reports that they did inform the physician but failed to document a. The clinical record document titled communication. Narrative "Skilled Nursing Assessment" signed by addendum for that visit was Employee D, a registered nurse (RN), on added to clinical record. See 1/4/12, stated under vital signs, "BP Attachment B. Clinical record #3, [Blood Pressure] sitting 172/82." On administrator reviewed with Employee I the importance of page 2 of this skilled nursing assessment measuring wounds and under cardiovascular -- SN [Skilled accurately documenting the Nurse] instructed pt/cg [patient/caregiver] assessment of length, width, and on: BP rechecked: 156/80. depth. Clinical record #11, administrator provided education to nursing staff regarding all b. The POC states, "SN to inform the skilled nursing services must physician if the SBP [systolic blood follow the written POC as ordered pressure] is greater than 160 mmHg by the physician. Administrator also reviewed policy and [millimeters of mercury]." procedures with Employee H and staff that any changes in the POC

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Event ID: TRZ911

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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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG must be reviewed and signed by c. On 1/11/12 at 3:20 PM, the the physician prior to carrying out administrator indicated the systolic blood any nursing interventions. In pressure reading was over the parameter addition, emphasized that all of 160 mmHg and was to be called in to medications need to be included the physician as ordered on the POC. in the POC and all wound care should correspond with a physician order or POC. 10% of 2. Clinical record #3, SOC 10/14/11, clinical records will be audited included a plan of care for certification quarterly to ensure services periods of 10/14/11 - 12/12/11 and provided follows physician written order and the established POC. 12/14/11 - 2/10/12. The recertification Administrator and Director of assessment completed by Employee I, Nursing will be responsible for Registered Nurse, on 12/8/11 identified educating the staff regarding the patient POC and monitor the patient had 2 wounds. The area on the compliance to policy and left buttocks indicated two pressure procedures to ensure this wounds at sites A and B. The wound deficiency is corrected and will description lacked measurements of the not reoccur. length, width and depth of these wounds. a. The plan of care dated and signed by Employees A and C, Registered Nurses on 10/14/11 for the certification period of 10/14/11 - 12/12/11 stated the following: "Orders for Discipline and Treatments (Specify amount/frequency/duration): Skilled nursing is to assess pt.'s [patient's] physical and mental status ..." b. On 1/11/12 at 3:40 PM, the administrator indicated skilled nursing did not assess the patient's physical status by measuring the wounds as indicated on the POC. 3. Clinical record #11, SOC 9/20/11, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TRZ911 Facility ID: 011121 If continuation sheet Page 12 of 53

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) D.	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING 00				OMPLETED /12/2012
			5. ()	-	ADDRESS, CITY, STATE, ZIP CO	DE	
NAME OF	PROVIDER OR SUPPLIE	eR		1947 H	ARDER CT STE B		
ASSURE	ED HOME HEALTH	ICARE INC		SCHER	RERVILLE, IN 46375		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	included a plan						
	-	riod of 9/30/11 - 11/28/11,					
		ce an accurate POC as					
	evidenced by th	e following documents					
		The POC failed to					
	evidence an ord	ler for wound care or					
	medicated pow	der. This POC was signed					
	on 9/30/11 and	dated by Employees C and					
	H, RNs.						
	a The init	ial and assessment					
	document titled						
		Formation Set (Oasis-C)					
		ersion" with a date of					
	-	ned by Employee H stated,					
		Status: Surgical Wounds					
		ker implementation. This					
		cribed to be in the trunk					
		wound, length 5 cm, no					
		ising, attached edges,					
		ding tissue, dressing type					
		ew evaluation." At the					
		ssment, a narrative stated,					
		rding limitations to left					
	shoulder and w	ound care dressings."					
	b. A clinic	al document dated 10/4/11					
	titled "Skilled N	Nursing Assessment -					
	Notes" was sign	ned by patient #11 and					
	Employee H, R	N, under patient caregiver					
		ed, "Wound care done."					
		nd section of this					
	assessment, the	nurse stated, "Site left					
		with normal saline,					
		······································			1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	00	(X3) DATE SURVEY COMPLETED		
		157581	B. WING		_	01/12/2012	
	PROVIDER OR SUPPLIE		1947 H	ADDRESS, CITY, STATE, ZIP IARDER CT STE B RERVILLE, IN 46375	CODE		
				RERVILLE, IN 40375			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE C	(X5) OMPLETIC DATE	
	covered with no secured with tap	on-adherent dressing, and pe."					
	"Resumption of Stay" dated 10/ Employee H sta medication with	cal document titled f Care following Inpatient 13/11 and signed by ated, "Teachings regarding a small excoriated area ast note of apply medicated thing."					
	administrator in application of n	D. On 1/11/11 at 3:50 PM, the nistrator indicated no wound care or cation of medicated powder were ded on the POC.					
	Care with no ef plan of care sho implemented, a with the patient interdisciplinar in the patient's	policy titled Patient Plan of fective date stated, "The buld be developed, and revised in coordination t, the physician, and the y team members involved care, in accordance with ards of practice."					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG G0229 The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's G0229 home no less frequently than every 2 weeks. The alternate administrator 01/27/2012 in-serviced all skilled nurses and Based on clinical record review and home health aides that a policy review and interview, the agency supervisory visit must be done failed to ensure the registered nurse made every 2 weeks and an on-site visit with the HHA be done every 30 on-site visits to the patient's home no less days. Home health aide frequently than every 2 weeks for 3 of 8 supervision policy was clinical records reviewed of patients with reinforced. The field nursing skilled and home health aide services. supervisor will monitor frequency (Clinical records #1, #2, and #11). of HHA visits for accuracy and completeness. 10% of clinical records will be audited quarterly Findings to ensure home health aide supervision visits were performed according to policy. Administrator 1. Clinical record #1 included a plan of will be responsible for monitoring care (POC) for the certification period compliance to ensure this 10/11/11 - 12/9/11 with orders for home deficiency is corrected and will health aide services two times a week for not reoccur. 8 weeks and 1 times a week for 1 week. The record failed to evidence any supervisory visits from 10/11/11 - 12/9/11 despite aide visits which occurred as ordered on the POC. 2. Clinical record #2 included a POC for the certification period 12/20/11 - 2/17/12with orders for home health aide services three times a week for two weeks and two times a week for seven weeks. The record failed to evidence any supervisory visits from 12/20/11 through 1/12/12 despite aide visits which occurred as ordered on the POC.

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Facility ID: 011121

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZI		(X3) DATE SURVEY COMPLETED 01/12/2012		
	PROVIDER OR SUPPLIEF			STREET A 1947 HA SCHER	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED 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) Completio Date	
	<ul> <li>the certification with orders for he two times a week record failed to evisits made durin visits which occe POC.</li> <li>4. On 1/11/12 a administrator indivisits were evided records.</li> <li>5. The agency period stated, "Supervision stated, "Supervision stated, "Supervision stated, "Supervision stated, "Supervision to assess services are beind with the plan of The registered near the supervision stated is present to when the aide at the supervision to assess the supervision stated is present to the supervision stated is present to when the aide at the supervision state at the supervision state of the supervision state supervision to assess the supervision to assess the supervision to assess the supervision state at the superv</li></ul>	rd #11 included a POC for period 9/30/11 - 11/28/11 iome health aide services k times 8 weeks. The evidence any supervisory ing this time despite aide urred as ordered on the t 3:15 PM, the dicated no supervisory enced in these clinical olicy titled "Home Health in" with no effective date sor visits are made to ered nurses and the nurse sure that home health aide ig provided in accordance care and Agency policy urse makes a home health visit to the patient at weeks, either when the o observe and assist, or osent, to assess the determine whether goals						

# 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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG G0236 A clinical record containing pertinent past and current findings in accordance with accepted professional standards is G0236 maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. The alternate administrator 01/27/2012 in-serviced all staff regarding Based on clinical record and policy documenting corrections in the review and interview, the agency failed to clinical records. Clinical data ensure clinical records were maintained collection policy was reinforced. 10% of clinical records will be per agency policy for 1 of 12 records audited guarterly to ensure reviewed (Clinical record #8). clinical records with errors are corrected per policy. Findings Administrator will be responsible for monitoring compliance to ensure this deficiency is corrected 1. Clinical record #8, start of care and will not reoccur. 9/26/11, evidenced documents with dates altered on the following clinical documents: a. The clinical document titled "HCFA [Health Care Financing Administration] Medical Information Release Authorization" signed by the patient with a date of 9/26/11 and signed by Employee F with a date of 9/26/11. Both dates had been altered with the "6" written over another number. The other number written below this superimposed number could no longer be read. Facility ID: 011121

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Event ID: TRZ911

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) DA	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	AB	UILDING	00	CO	MPLETED	
		157581		ING		01/	/12/2012	
				STREET A	CODE			
NAME OF	PROVIDER OR SUPPLIE	R	1947 HARDER CT STE B					
ASSURE	D HOME HEALTH	ICARE INC		SCHER	RERVILLE, IN 46375			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	DROVIDED'S DLAN OF CO	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	1 751 1 1 1	1						
		document titled						
"Admission Checklist" with patient	-							
		of 9/26/11. This date had						
	been altered wit	th the "6" written over						
		mber now illegible. The						
	document also	evidenced referral form						
	date completed	: 9/26/11 and date received						
	9/26/11, Physic	ian telephone and other						
	verbal orders da	ate completed: 9/26/11 and						
	date received 9/	26/11, patient's rights and						
		date completed 9/26/11,						
	-	ves date completed						
		discharge plan date						
		/11. Each "6" had been						
	-	th another number now						
	illegible.							
	inegiote.							
	c. The clinical	document titled "Medicare						
	Questionnaire"	with the patient #8's						
	signature with v	written date of 9/26/11 and						
	-	ignature with the written						
	1 5	Each "6" in the written						
		nature of the patient and						
		the employee had been						
	-	other number now						
	illegible.							
	d. The clinical	document titled "Patient						
		ponsibilities" with the						
	-	ne and date of 9/26/11 at						
	-	f the listed patient rights						
		ities. The rights follow.						
	-	e document, the patient						
	At the end of th	e document, me patient						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Č,	MULTIPLE CO	ONSTRUCTION 00	. ,	TE SURVEY MPLETED
		157581	B. WING			- 01/12/2012	
NAME OF	PROVIDER OR SUPPLIE	R		STREET /	ADDRESS, CITY, STATE, ZIP COI	DE	
	ED HOME HEALTH				ARDER CT STE B RERVILLE, IN 46375		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	JLD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	ne date of 9/26/11 and					
		ignature with date of					
		"6" in the written dates by					
	-	the patient and the					
	-	employee had been					
	written over wi illegible.	th another number now					
		document titled "Drug					
	U	w" with the patient name					
		the patient's medications					
		ate of 9/26/11. The "6" in					
		en written over with					
		now illegible. Employee					
	F's signature is	written in the signature					
	box.						
		document titled "Start of					
		with the start of care date of					
		e assessment completed of					
		5" and "8" have been					
		th other numbers now					
	•	document ends with the					
	-	patient on 9/28/11 and					
		ignature also signed on					
	9/28/11. Each	"6" in the written dates by					
	-	the patient and the					
	-	employee had been					
	written over wi	th another number now					
	illegible.						
	2. On 1/12/12 a	at 1:15 PM, the					
	administrator in	dicated the numbers had					
	been altered and	d not corrected per agency					

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	A. BUILDING B. WING	00	COM	te survey 1pleted 12/2012
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C IARDER CT STE B	ODE	
ASSUR	ED HOME HEALTH	CARE INC		RERVILLE, IN 46375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR 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
	policy number of revision date of in documentatio follows: Draw a date and initial.	policy titled e data collection" with a of C:2-033.1 with a May 2010 stated, "Errors on will be corrected as line through the entry, Do not erase, use or deface a document."				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 BUILDING 157581 01/12/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG G0334 The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no G0334 later than 5 calendar days after the start of care. The administrator in-services 02/06/2012 Based on clinical record and policy nursing staff regarding review and interview, the agency failed to completion of the comprehensive ensure the wound assessment completed assessment per policy. by the registered nurse as part of the Reinforcement will be given to the nurses that all pertinent physical comprehensive assessment was complete findings must be documented in for 1 of 12 records reviewed (clinical their assessment. Clinical record #3). record #3, administrator reviewed with Employee I the importance of measuring wounds and Findings include accurately documenting the assessment of length, width, and 1. Clinical record #3, start of care depth. 10% of all clinical records 10/14/11, evidenced a recertification will be audited quarterly for assessment completed by Employee I, evidence that the comprehensive assessment documentation is Registered Nurse, on 12/8/11 with a complete and that all pertinent wound assessment. The area on the left physical findings are reported in a buttocks indicated two pressure wounds at timely manner. Administrator and director of nursing will be sites A and B. The wound description responsible for monitoring these lacked measurements of the length, width corrective actions to ensure that and depth. this deficiency is corrected and will no recur. 2. On 1/11/12 at 3:40 PM, the administrator indicated that the wound assessment on the comprehensive assessment was not complete. 3. The agency policy titled "Initial and Comprehensive Assessment" stated, "Purpose: To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of

Facility ID: 011121

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		157581	B. WING		01/12/2012
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP CO ARDER CT STE B	DE
ASSURE	ED HOME HEALTH	ICARE INC		RERVILLE, IN 46375	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	
	care. Policy Ar	n initial patient assessment			
	will be perform	ed and documented in the			
	patient's clinica	l record by a registered			
	nurse A com	prehensive patient			
	assessment will	be completed within 5			
	calendar days o	f the patient's start of care.			
	-	t will be patient- specific			
		sive to include the patient's			
	-	care, rehabilitative care,			
		harge planning needs. The			
	· · · · · · · · · · · · · · · · · · ·	also include the exact use			
	of the current v	ersions of the Outcomes			
		t information set (Oasis)			
		sive assessment for each			
	-	e completed in its entirety			
	-	ician. During the initial			
		sive patient assessment, all			
	-	be used in measuring the			
		ss towards goals and other			
		ation will be documented			
		clinical records A			
	_	ment, including blood			
	1 2	erature, height/weight,			
		is and other relevant data			
		ent physical findings."			
		ient physical mulligs.			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES FOD MEDICADE & MEDICAID SEDVIC

PRINTED: 02/06/2012 FORM APPROVED OMD NO 0039 0301

	R MEDICARE & MEDI				OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157581	B. WING		01/12/2012
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	-
				ARDER CT STE B	
ASSURE	ED HOME HEALTH	ICARE INC	SCHEI	RERVILLE, IN 46375	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
G0337	1	sive assessment must			
		of all medications the patient g in order to identify any			
		e effects and drug reactions,	G0337		
		tive drug therapy, significant			
	-	nificant drug interactions,			
		nerapy, and noncompliance			
	with drug therap	y.			
				The administrator in-services	02/06/2012
	Based on clinic	al record review, policy		nursing staff on maintaining the drug regimen review and the	ne
	review, and inte	erview, the agency failed to		policy of updating the	
	ensure current r	nedications were		medications. Reinforcement	will
	accurately listed	d according to professional		be given to the staff regarding	
	-	e medication profile for 2		policy of reviewing all patient	
		cords reviewed (Clinical		medications. Clinical record	
	record #1 and #	· ·		on 1/13/12 an addendum orde	
		11).		for correction on the POC was written to include the new	5
	<b>F</b> ' 1'			medications on the plan of ca	re
	Findings			as ordered. See attachment	
				Clinical record #11, administra	ator
		ord #1, start of care (SOC)		provided education to nursing	
		tification period 12/10/11		staff regarding all skilled nurs	
		to evidence an updated		services must follow the writte POC as ordered by the	
	· ·	file as noted by the		physician. It was also	
	following docu	ments and interview:		emphasized that all medication	ons
				need to be included in the PC	C.
	A. A physic	cian's order signed by		10% of all clinical records will	
		egistered Nurse (RN) and		audited quarterly for evidence	
	1 2 7	tated, "Order: PLS [please]		the comprehensive assessme includes a review of all	ent
		fication dates from		medications the patient is	
		2. Continue SN [skilled		currently taking and that the c	Irug
		-		regimen review is is kept up to	
		A [Home health aide ] visit		date. Administrator and Direc	
		and treatment New		of nursing are responsible for	
	-	ons]: Colchicine 0.6 mg		monitoring these corrective	
	[milligram] tab	[tablet] every 2 hrs		actions to ensure that this	
	[hours] po [by 1	nouth] prn [as needed] for		deficiency is corrected and wind not recur.	"

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CORRECTION IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		157581	B. WI	B. WING		01/	12/2012
NAME OF	PROVIDER OR SUPPLIE	۵. ۵	-	STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	FROVIDER OR SUFFLIE			1947 H/	ARDER CT STE B		
ASSURI	ED HOME HEALTH	ICARE INC		SCHER	ERVILLE, IN 46375		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	pain, hydrocode	one/apap [acetaminophen]					
	100/650 mg tab	every 6 hrs po prn for					
	pain."						
	<b>D</b> 4 11 1	1 11					
		cal record document titled					
		Review" with review					
		1, 8/10/11, 10/16/11 and					
	-	ned by Employee C RN					
	failed to list Co						
	hydrocodone/ap	pap.					
	$C_{\rm op} 1/11$	1/12 at 3:15 PM, the					
		ndicated the colchicine and					
		PAP were not included on					
	the medication						
		prome.					
	2. Clinical reco	ord #11, SOC 9/20/11 with					
	a certification p	period of 9/30/11 -					
	-	l to evidence an updated					
		file initiated by the RN as					
	-	ne following documents					
	and interview:	0					
	A. The plan	n of care with a					
	certification per	riod of 9/30/11 - 11/28/11					
	failed to eviden	ce an order for medicated					
	powder. This F	POC was signed on 9/30/11					
	-	mployee C and H, both					
	RNs.						
		cal document titled					
	-	f Care following Inpatient					
		13/11 and signed by					
	Employee H sta	ated, "Teachings regarding					

STATEME	XII PROVIDER/SUPPLIER/CLIA           VD PLAN OF CORRECTION         IDENTIFICATION NUMBER:		MULTIPLE CO	(X3) DA	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		157581	3. WING		01/12/20	
NAME OF	PROVIDER OR SUPPLIEF	1		ADDRESS, CITY, STATE, ZIP ARDER CT STE B	CODE	
ASSURE	ED HOME HEALTH	CARE INC		RERVILLE, IN 46375		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC DATE
	medication with	small excoriated area				
	under right breas	st note apply medicated				
	powder after bat	hing."				
	C. On 1/11/	/11 at 3:50 PM, the				
		dicated the application of				
	· ·	er was not included on				
	the medication p	orofile.				
	3. The agency p	olicy titled "Medication				
	-	olicy number HH:2-028.1				
		ate of May 2010 stated,				
	"A drug regimer					
	-	time of admission, when				
	-	omprehensive assessments when care is resumed after				
	-	en placed on hold, and				
	-	n of a new medication."				
	1			1		1

## 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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG N0446 Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may N0446 also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Performance evaluation was 01/13/2012 Based on personnel file review, interview, immediately done on employee of and policy review, the agency failed to personnel file A by member of the ensure that 1 of 1 administrator had an board of directors January 13, annual evaluation as required by agency 2012. See Attachment A. Administrator in-serviced human policy. (file A) resources in updating employee files and keeping employee Findings records current. 100% of employee files will be audited yearly for evidence that a 1. Personnel file A, date of hire 6/12/06, performance evaluation is failed to evidence an annual performance completed. Administrator is evaluation. responsible for monitoring compliance in the conduction of 2. On 1/12/12 at 3 PM, the administrator annual performance evaluations and ensure that this deficiency is indicated the annual evaluation had not corrected and will not recur. been completed per agency policy. 3. The agency policy titled "Performance Evaluation" with no effective date states, "A competency-based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."

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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 00 COMPLETED . BUILDING 157581 01/12/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG N0456 Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: N0456 (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Quality assurance program was 01/13/2012 Based on document review and interview, reviewed and discussed with the the administrator failed to ensure the Performance Improvement ongoing quality assurance program was Committee January 13, 2012. designed to objectively evaluate the The program was restructured to reflect the immediate needs of quality and appropriateness of patient the agency and begin clinical care, resolve identified problems, and record reviews on a quarterly improve patient care for 1 of 1 agency basis. It was further established with the potential to affect all the agency's that educational in-services to the staff be done on those identified patients. deficiencies, and follow-up of those deficiencies be randomly Findings include reviewed in the clinical records. Documentation of progress will be measured objectively and 1. On 1/12/12 at 1:45 PM, the quantitatively to demonstrate administrator and alternate administrator compliance or resolution. indicated the quality assurance program Director of Nursing and failed to evidence a quality assurance Performance Improvement program that objectively and Coordinator is responsible for monitoring compliance to policy systematically monitored and evaluated and procedures regarding the the quality and appropriateness of patient quality assurance program and care and identified problem resolution and will educate responsible staff the patient care improvement. importance of maintaining program. Board of directors will review this bi-yearly for evidences 2. The agency document titled "Clinical of an established quality record review Target Outcome: assurance program. First clinical Improvement in Ambulation/Locomotion" record review will be done by February 1, 2012 and deficiencies with a signature from Employee C will be identified the same Registered Nurse (RN) and no date states, day. In-service topic for February

Event ID: TRZ911

Facility ID: 011121

If continuation sheet

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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 00 COMPLETED . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG month will be related to problems "Best Practice Care Behaviors" with identified from clinical record clinical record numbers for 5 records. 13 review. Six month time frame will best practice care behaviors were selected be allowed for improvement and and checked off in each of the 5 records by August 1,2012 a follow-up audited. No deficient practices were audit of the charts will be done for evaluation. noted on this audit and no follow-up was found. 3. The agency document titled "Clinical record review Target Outcome: Improvement in Transferring' with a signature from Employee C RN and no date states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 4. The agency document titled "Clinical record review Target Outcome: Improvement with pain during activity" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 14 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 5. The agency document titled "Clinical record review Target Outcome: State Form Event ID: TRZ911 Facility ID: 011121 If continuation sheet Page 28 of 53

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING	COMPLETED - 01/12/2012	
			B. WING	ADDRESS CITY STATE 71D C	ODE
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP C ARDER CT STE B	ODE
ASSURI	ED HOME HEALTH	ICARE INC		RERVILLE, IN 46375	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	
PREFIX		ENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	PPROPRIATE
TAG		DR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Improvement in	-			
	incontinence/B	ladder control" with a			
	signature from	Employee C and no date			
	noted states, "E	Best Practice Care			
	Behaviors" wit	h clinical record numbers			
	for 5 records.	11 best practice care			
	behaviors were	selected and checked off			
	in each of the 5	records audited. No			
	deficient practi	ces were noted on this			
	-	llow-up was found.			
		1			
	6. The agency	document titled "Clinical			
		Farget Outcome:			
		n Bathing" with a signature			
	-	e C and no date noted			
		actice Care Behaviors"			
		cord numbers for 5			
		st practice care behaviors			
		nd checked off in each of			
		udited. No deficient			
		noted on this audit and no			
	follow-up was	iouna.			
	7. The agency	document titled "Clinical			
		Farget Outcome:			
	Improvement in	n Management of Oral			
	Meds" with a s	ignature from Employee C			
	and no date not	ted states, "Best Practice			
	Care Behaviors	" with clinical record			
	numbers for 5 i	records. 17 best practice			
		were selected and checked			
		he 5 records audited. No			
		ces were noted on this			
	-	llow-up was found.			

	ERS FOR MEDICARE & MEDICAID SERVICES			FORM A OMB NO					
	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581		ILDING NG	NSTRUCTION 00	CON 01/	DATE SURVEY OMPLETED 1/12/2012		
NAME OF P	ROVIDER OR SUPPLIER	L			DDRESS, CITY, STATE, ZIP	P CODE			
ASSURE	D HOME HEALTH	CARE INC			ARDER CT STE B ERVILLE, IN 46375				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
	record review Ta Improvement in signature from E noted states, "Be Behaviors" with for 5 records. 12 behaviors were s in each of the 5 r deficient practice	Dyspnea" with a Employee C and no date							

## 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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG N0458 Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in N0458 Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Performance evaluation was 01/13/2012 Based on personnel file review, interview, immediately done on employee of and policy review, the agency failed to personnel file A by member of the ensure that 1 of 1 administrator had an board of directors January 13, annual evaluation as required by agency 2012. See Attachment A. Administrator in-serviced human policy. (file A) resources in updating employee files and keeping employee Findings records current. 100% of employee files will be audited yearly for evidence that a 1. Personnel file A, date of hire 6/12/06, performance evaluation is failed to evidence an annual performance completed. Administrator is evaluation responsible for monitoring compliance in the conduction of 2. On 1/12/12 at 3 PM, the administrator annual performance evaluations and ensure that this deficiency is indicated the annual evaluation had not corrected and will not recur. been completed per agency policy. 3. The agency policy titled "Performance Evaluation" with no effective date states, "A competency-based performance evaluation will be conducted for all State Form Event ID: TRZ911 Facility ID: 011121 If continuation sheet Page 31 of 53

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	te survey Mpleted 12/2012
NAME OF	PROVIDER OR SUPPLIEI	2		ADDRESS, CITY, STATE, ZIP	CODE	
ASSURE	ED HOME HEALTH	CARE INC		ARDER CT STE B RERVILLE, IN 46375		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	employees after at least annually	1 year of employment and thereafter."				

#### 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 00 COMPLETED . BUILDING 157581 01/12/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG N0472 Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and N0472 performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. 01/13/2012 Quality assurance program was Based on document review and interview, reviewed and discussed with the the agency failed to ensure the ongoing Performance Improvement quality assurance program was designed Committee January 13, 2012. to objectively evaluate the quality and The program was restructured to reflect the immediate needs of appropriateness of patient care, resolve the agency and begin clinical identified problems and improve patient record reviews on a quarterly care for 1 of 1 agency. basis. It was further established that educational in-services to the staff be done on those identified Findings include deficiencies, and follow-up of those deficiencies be randomly 1. On 1/12/12 at 1:45 PM, the reviewed in the clinical records. administrator and alternate administrator Documentation of progress will be measured objectively and indicated the quality assurance program guantitatively to demonstrate failed to evidence a quality assurance compliance or resolution. program that objectively and Director of Nursing and systematically monitored and evaluated Performance Improvement the quality and appropriateness of patient Coordinator is responsible for monitoring compliance to policy care and identified problem resolution and and procedures regarding the patient care improvement. quality assurance program and will educate responsible staff the 2. The agency document titled "Clinical importance of maintaining program. Board of directors will record review Target Outcome: review this bi-yearly for evidences Improvement in Ambulation/Locomotion"

Event ID: TRZ911

11 Facility ID

Facility ID: 011121

If continuation sheet Pa

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PRINTED:

FREET ADDRESS, CITY, STATE, ZIP CODE         947 HARDER CT STE B         CHERERVILLE, IN 46375         0       PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X: COMPLI DAT         0f an established quality assurance program. First clinical record review will be done by February 1, 2012 and deficiencies will be identified the same day. In-service topic for February month will be related to problems identified from clinical record review. Six month time frame will be allowed for improvement and by August 1,2012 a follow-up audit of the charts will be done for evaluation.
D         PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         (X: COMPLIE DAT           AG         of an established quality assurance program. First clinical record review will be done by February 1, 2012 and deficiencies will be identified the same day. In-service topic for February month will be related to problems identified from clinical record review. Six month time frame will be allowed for improvement and by August 1,2012 a follow-up audit of the charts will be done for

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING B. WING	COMPLETED 01/12/2012	
				ADDRESS, CITY, STATE, ZIP COD	E
NAME OF	PROVIDER OR SUPPLIE	R		IARDER CT STE B	
ASSURE	ED HOME HEALTH	ICARE INC	SCHEF	RERVILLE, IN 46375	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE	ROPRIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		document titled "Clinical			
		Target Outcome:			
	Improvement in	2			
		adder control" with a			
	•	Employee C and no date			
	-	est Practice Care			
		n clinical record numbers			
		1 best practice care			
		selected and checked off			
	in each of the 5	records audited. No			
	deficient praction	ces were noted on this			
	audit and no fol	low-up was found.			
	6. The agency d	locument titled "Clinical			
	record review T	arget Outcome:			
	Improvement in	Bathing" with a signature			
	from Employee	C and no date noted			
	states, "Best Pra	actice Care Behaviors"			
	with clinical rec	cord numbers for 5			
	records. 13 bes	t practice care behaviors			
	were selected an	nd checked off in each of			
	the 5 records au	dited. No deficient			
	practices were i	noted on this audit and no			
	follow-up was f	found.			
	7. The agency	document titled "Clinical			
	record review T	Target Outcome:			
	Improvement in	n Management of Oral			
	Meds" with a si	gnature from Employee C			
	and no date not	ed states, "Best Practice			
		" with clinical record			
	numbers for 5 r	ecords. 17 best practice			
		were selected and checked			
	off in each of th	ne 5 records audited. No			

NTERS FOR MEDICAR	RS FOR MEDICARE & MEDICAID SERVICES			ОМІ					
STATEMENT OF DEFIC	· /		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTIO	ON	СОМ	ATE SURVEY DMPLETED 1/12/2012		
NAME OF PROVIDER O	R SUPPLIER				CITY, STATE, ZIP COD	E			
ASSURED HOME	HEALTHCARE INC			7 HARDER ( IERERVILLE					
PREFIX (EAC	UMMARY STATEMENT OF DEFIC H DEFICIENCY MUST BE PERCEI LATORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	(EACH C	OVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOUI EFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETIC DATE		
	t practices were noted or d no follow-up was foun								
record i Improv signatu noted s Behavi for 5 re behavio in each deficien	agency document titled " eview Target Outcome: ement in Dyspnea" with a re from Employee C and fates, "Best Practice Care ors" with clinical record r cords. 12 best practice ca ors were selected and cheat of the 5 records audited. It practices were noted or and no follow-up was foun	a no date numbers are cked off No n this							

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

 PRINTED:
 02/06/2012

 FORM APPROVED

 OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	OM (X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		00	COMPL	
		157581		LDING		01/12	/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CHIT, STATE, ZIP CODE		
ASSURE	D HOME HEALTH				RERVILLE, IN 46375		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG 10522		a) Medical care shall follow a		TAG	Direiter)		DATE
NUJZZ		plan of care established and					
		ewed by the physician,					
	dentist, chiropra	ctor, optometrist or podiatrist,	N	)522			
	as follows:						
	Based on clinical record and policy				The administrator will in-service	e	02/06/201
	review, and inte	erview, the agency failed to			nursing staff that all provided services follows a written order	r	
	ensure skilled nurse services were				signed by a physician.	1	
	provided as ord	ered on the plan of care for			Reinforcement will be given to	the	
	3 of 12 records (Clinical record #2, 3, and				staff that all skilled nursing		
	11) with the pot	tential to effect all of the			services should be provided in		
	patients of the a	igency.			accordance to the written plan care (POC) or written physicia		
	1				order. Administrator will inform		
	Findings				staff that any changes in the F		
	1 manigo				need to be reviewed and sign		
	1 Clinical reco	ord #2, start of care (SOC)			by the physician. Clinical reco		
				#2, administrator discussed w			
		/20/11, included a plan of care with a rtification period of $12/20/11 - 2/17/12$ .			employee D regarding visit on 1/4/12 about the BP over the		
	-				ordered parameter as written	n	
					the POC. Employee D reports		
	care (POC) as e	videnced by the following:			that they did inform the physic		
					but failed to document		
		ical record document titled			communication. Narrative		
		g Assessment" signed by			addendum for that visit was added to clinical record. See		
	Employee D, a	registered nurse (RN), on			Attachment B. Clinical record	#3.	
	1/4/12, stated u	nder vital signs, "BP			administrator reviewed with	-,	
	[Blood Pressure	e] sitting 172/82." On			Employee I the importance of		
	page 2 of this sl	cilled nursing assessment			measuring wounds and		
		cular SN [Skilled			accurately documenting the	nd	
		ed pt/cg [patient/caregiver]			assessment of length, width, a depth. Clinical record #11,	μu	
	on: BP recheck				administrator provided educat	ion	
					to nursing staff regarding all		
	h The PO(	C states, "SN to inform the			skilled nursing services must		
		SBP [systolic blood			follow the written POC as orde		
					by the physician. Administrate	or	
		ater than 160 mmHg			also reviewed policy and procedures with Employee H	and	
	[millimeters of	mercury]."					

STATEMENT OF DE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	È,		ONSTRUCTION		FE SURVEY IPLETED	
		157581		UILDING ING		- 01/2	01/12/2012	
NAME OF PROVIDE	R OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C ARDER CT STE B	ODE		
ASSURED HOM	IE HEALTH	ICARE INC			RERVILLE, IN 46375			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)	
,		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC DATE	
adm press of 16 the p 2. (C inclu period 12/1 asses Regi the p left b wour desc leng by E on 1 10/1 "Ord (Spe Skill phys	nistrator in sure reading 50 mmHg a hysician as Clinical rec- ded a plan ods of 10/14 4/11 - 2/10, ssment com- stered Nurs- atient had 1 outtocks inco- nds at sites ription lack h, width ar a. The plan mployees 4 0/14/11 for 4/11 - 12/1 ers for Dis cify amour- ed nursing ical and mo- b. On 1/11 nistrator in ssess the p- guring the v	/12 at 3:20 PM, the adicated the systolic blood g was over the parameter and was to be called in to s ordered on the POC. ord #3, SOC 10/14/11, of care for certification 4/11 - 12/12/11 and /12. The recertification apleted by Employee I, se, on 12/8/11 identified 2 wounds. The area on the dicated two pressure A and B. The wound ted measurements of the nd depth of these wounds. an of care dated and signed A and C, Registered Nurses the certification period of 2/11 stated the following: cipline and Treatments at/frequency/duration): is to assess pt.'s [patient's] ental status" /12 at 3:40 PM, the adicated skilled nursing did atient's physical status by younds as indicated on the			staff that any changes must be reviewed and the physician prior to c any nursing interventio addition, emphasized t medications need to be in the POC and all wou should correspond with physician order or POC Administrator and Direc Nursing will be respons educating the staff rega patient POC and monit compliance to policy ar procedures. 10% of cli records will be audited to ensure services prov follows physician writte and the established PC	signed by arrying out ns. In hat all e included and care n a C. ctor of sible for arding the or nd inical quarterly <i>v</i> ided en order		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION	(X3) D	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING 00 B. WING			COMPLETED 01/12/2012	
			D. 11		ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF	PROVIDER OR SUPPLIE	ER		1947 HA	ARDER CT STE B		
	D HOME HEALTH	ICARE INC			ERVILLE, IN 46375		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETIC DATE
IAU		,		IAU	DLi (cl.) (cl.)		DATE
		ord #11, SOC 9/20/11,					
	included a plan						
	· ·	riod of 9/30/11 - 11/28/11,					
		ce an accurate POC as					
		ne following documents					
		The POC failed to					
		ler for wound care or					
	-	der. This POC was signed					
		dated by Employees C and					
	H, RNs.						
		ial and assessment					
	document titled						
		formation Set (Oasis-C)					
	Start of Care V	ersion" with a date of					
	-	ned by Employee H stated,					
		Status: Surgical Wounds					
	1 1	ker implementation. This					
		cribed to be in the trunk					
		wound, length 5 cm, no					
		sing, attached edges,					
	normal surroun	ding tissue, dressing type					
		new evaluation." At the					
		ssment, a narrative stated,					
		rding limitations to left					
	shoulder and w	ound care dressings."					
	b. A clinic	al document dated 10/4/11					
	titled "Skilled N	Nursing Assessment -					
	Notes" was sign	ned by patient #11 and					
	Employee H, R	N, under patient caregiver					
		ed, "Wound care done."					
		nd section of this					
	assessment, the	nurse stated, "Site left					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MU A. BUII B. WIN	G	DING 00 COMP. 01/12		
	PROVIDER OR SUPPLIEF			1947 HA	ADDRESS, CITY, STATE, ZIP ARDER CT STE B ERVILLE, IN 46375	CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE	
		with normal saline, n-adherent dressing, and e."					
	"Resumption of Stay" dated 10/1 Employee H star medication with under right brear powder after bat D. On 1/11, administrator in	/11 at 3:50 PM, the dicated no wound care or edicated powder were					
	Care with no eff plan of care shou implemented, ar with the patient, interdisciplinary	policy titled Patient Plan of Pective date stated, "The add be developed, ad revised in coordination the physician, and the team members involved are, in accordance with rds of practice."					

STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUI B. WIN	LDING G	00	COMPLETED 01/12/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLI	R		1947 H	HARDER CT STE B		
ASSURED HOME HEALTH	ICARE INC		SCHE	RERVILLE, IN 46375		
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETIO
	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
plan of care sha(A) Be develophome health ag(B) Include all askilled service is(B) Cover all pe(C) Include the(i) Mental sta(ii) Types of arequired.(iii) Frequence(iv) Prognosis(v) Rehabilita(vi) Functiona(vii) Activities p(viii) Nutritional(ix) Medication(x) Any safetiinjury.(xi) Instructionreferral.(xii) Therapy pertreatment.(xiii) Any otherBased on clinicareview and interensure current from the patients of theFindings include1. Clinical records#1 and #11) withe patients of theFindings include1. Clinical records#1 and #11 and cer- 2/7/12, failed	ed in consultation with the ency staff. services to be provided if a s being provided. ertinent diagnoses. following: atus. services and equipment $\gamma$ and duration of visits. tion potential. I limitations. bermitted. requirements. ons and treatments. by measures to protect against ins for timely discharge or modalities specifying length of appropriate items. al record and policy review, the agency failed to medications and treatments he plan of care for 2 of 12 reviewed (Clinical record th the potential to effect all the agency.	N	0524	The administrator will in-servi nursing staff that all provided services follows the written medical POC. Reinforcement be given to the staff that all st nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator informed staff th any new orders, especially all patient medications, need to I updated in the written POC all signed by the physician. Cli record #1, on 1/13/12 an addendum order for correction the POC was written to include	will killed nat oe nical n on	02/06/20

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	te survey 19leted 12/2012
	PROVIDER OR SUPPLIE		1947	T ADDRESS, CITY, STATE, ZIP ( HARDER CT STE B ERERVILLE, IN 46375	CODE	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O following docur A. A physic Employee C, R dated 12/7/11 s confirm: recerti 12/10/11 - 2/7/1 nurse] and HH/ diet medication meds [medicati [milligram] tab [hours] po [by 1 pain, hydrocodd 100/650 mg tab pain." B. A clinic "Home Health O Treatment with 12/10/11 - 2/7/1 Employees C an failed to eviden hydrocodone/ap C. On 1/11 administrator ir hydrocodone/A the plan of care 2. Clinical reco a certification p 11/28/11, failed	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) ments and interview: cian's order signed by egistered Nurse (RN) and tated, "Order: PLS [please] ification dates from 12. Continue SN [skilled A [Home health aide ] visit and treatment New ons]: Colchicine 0.6 mg [tablet] every 2 hrs mouth] prn [as needed] for one/apap [acetaminophen] o every 6 hrs po prn for every 6 hrs po prn for cal record document titled Certification and Plan of a certification period of 12 and signed by nd E, RNs, on 12/10/11, ice colchicine or oap. 1/12 at 3:15 PM the adicated the colchicine and PAP were not included on c. ord #11, SOC 9/20/11 with period of 9/30/11 - it to evidence an accurate ced by the following	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIONS CROSS-REFERENCED TO THE DEFICIENCY) the new medications of of care as ordered. S Attachment C. Clinica #11, administrator pro education to nursing s regarding all skilled nu services must follow th POC as ordered by th physician. Administra reviewed policy and p with Employee H and any changes in the PO reviewed and signed H physician prior to carry nursing interventions. emphasized that all m need to be included in 10% of all clinical reco audited quarterly for e the medical plan of ca all patient medications Administrator and Dire nursing is responsible monitoring these corre actions to ensure that deficiency is corrected not recur.	SHOULD BE APPROPRIATE on the plan ee al record ovided staff ursing he written e tor also rocedures staff that DC must be by the ying out any In addition, hedications on the POC. ords will be evidence that are include s. ector of e for ective this	(X5) COMPLETIC DATE

	R MEDICARE & MEDIC					OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	Ĩ,	ILDING	00	CON	te survey Ipleted 12/2012	
NAME OF	PROVIDER OR SUPPLIEF	ξ			ADDRESS, CITY, STATE, ZIP CO	DE		
ASSUR	ED HOME HEALTH	CARE INC			ARDER CT STE B ERVILLE, IN 46375			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	FROFRIATE	DATE	
	<ul> <li>period of 9/30/1</li> <li>evidence an order</li> <li>This POC was side and the power of the power was included by Employ</li> <li>B. On 1/11/2</li> <li>administrator independent was included by a side and the power was included by the power was power with physicians</li> </ul>	2 with a certification 1 - 11/28/11 failed to er for medicated powder. igned on 9/30/11 and yees C and H, RNs. (11 at 3:50 PM, the dicated no medicated uded on the POC. locument titled "Job lled Nurse" with no sion date stated, "Duties ities Makes home physical assessments, t's needs and consults if necessary to develop documents appropriately manner."						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		157581	B. WING		01/12/2012	
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
				ARDER CT STE B		
ASSURE	ED HOME HEALTH	ICARE INC	SCHE	RERVILLE, IN 46375		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
N0537	shall provide nu nurse or a licens accordance with follows: Based on clinic review, and inte	The home health agency rsing services by a registered sed practical nurse in the medical plan of care as al record and policy erview, the agency failed to	rigency egistered n care as N0537 y failed to dad as		02/00/2012	
		ervices were provided as		signed by a physician.		
	-	plan of care for 3 of 12		Reinforcement will be given to	the	
	records (Clinica	al record #2, 3, and 11)		staff that all skilled nursing		
	with the potenti	al to effect all of the		services should be provided in accordance to the written plan		
	patients of the a	igency.		care (POC) or written physicia		
				order. Administrator informed		
	Findings			staff that any changes in the P need to be reviewed and signed	ed	
	1. Clinical reco	ord #2, start of care (SOC)		by the physician. Clinical reco #2, administrator discussed wi		
	12/20/11, inclue	led a plan of care with a		employee D regarding visit on		
	certification per	riod of 12/20/11 - 2/17/12.		1/4/12 about the BP over the		
	-	follow the written plan of		ordered parameter as written i		
		videnced by the following:		the POC. Employee D reports that they did inform the physic but failed to document		
	"Skilled Nursin Employee D, a 1/4/12, stated u [Blood Pressure	ical record document titled g Assessment" signed by registered nurse (RN), on nder vital signs, "BP e] sitting 172/82." On		communication. Narrative addendum for that visit was added to clinical record. See Attachment B. Clinical record a administrator reviewed with Employee I theimportance of measuring wounds and	#3,	
		killed nursing assessment		accurately documenting the		
		cular SN [Skilled		assessment oflength, width, a	nd	
		ed pt/cg [patient/caregiver]		depth. Clinical record #11,		
	on: BP recheck	red: 156/80.		administrator provided educati to nursing staff regarding all	ion	
	b. The PO	C states, "SN to inform the		skilled nursing services must follow the written POC as order	ared	
		SBP [systolic blood		by the physician. Administrate		
		ater than 160 mmHg		also reviewed policy and		
	[millimeters of	e		procedures with Employee H a	bne	

State Form

Event ID: TRZ911

Facility ID: 011121

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Č,	MULTIPLE CO	onstruction 00	r í	FE SURVEY IPLETED	
		157581	B. W			- 01/1	01/12/2012	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CO	DE		
ASSURE	ED HOME HEALTH	ICARE INC			IARDER CT STE B RERVILLE, IN 46375			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG	× ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	COMPLETIC DATE	
	administrator in pressure reading of 160 mmHg a the physician as 2. Clinical rece included a plan periods of 10/14 12/14/11 - 2/10, assessment com Registered Nurs the patient had 2 left buttocks ind wounds at sites description lack length, width ar a. The plan by Employees A on 10/14/11 for 10/14/11 - 12/12 "Orders for Dis (Specify amoun Skilled nursing physical and mo b. On 1/11, administrator in not assess the p	/12 at 3:20 PM, the dicated the systolic blood g was over the parameter nd was to be called in to s ordered on the POC. ord #3, SOC 10/14/11, of care for certification 4/11 - 12/12/11 and /12. The recertification upleted by Employee I, se, on 12/8/11 identified 2 wounds. The area on the dicated two pressure A and B. The wound ted measurements of the nd depth of these wounds. and C, Registered Nurses the certification period of 2/11 stated the following: cipline and Treatments tt/frequency/duration): is to assess pt.'s [patient's] ental status" /12 at 3:40 PM, the dicated skilled nursing did atient's physical status by younds as indicated on the			staff that any changes in must be reviewed and s the physician prior to ca any nursing intervention addition, emphasized th medications need to be in the POC and all wour should correspond with physician order or POC. Administrator and Direct Nursing will be responsi educating the staff regar patient POC and monito compliance to policy and procedures. 10% of clin records will be audited of to ensure services provi follows physician written and the established POC	igned by rrying out s. In at all included included included ad care a tor of ble for rding the r d incal juarterly ded i order		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157581	A. BUILDING B. WING	00	COMPLETED 01/12/2012	
				ET ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER		HARDER CT STE B	CODE	
ASSURE	D HOME HEALTH	ICARE INC		IERERVILLE, IN 46375		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		ord #11, SOC 9/20/11,				
	included a plan					
	· ·	riod of 9/30/11 - 11/28/11,				
	failed to eviden	ce an accurate POC as				
	evidenced by th	ne following documents				
	and interview:	The POC failed to				
	evidence an ord	ler for wound care or				
	medicated pow	der. This POC was signed				
	on 9/30/11 and	dated by Employees C and				
	H, RNs.	5 1 5				
	,					
	a. The init	ial and assessment				
	document titled					
		Cormation Set (Oasis-C)				
		ersion" with a date of				
		ned by Employee H stated,				
	-	v Status: Surgical Wounds				
		ker implementation. This				
	1 1	cribed to be in the trunk				
		wound, length 5 cm, no				
		using, attached edges,				
		ding tissue, dressing type				
		• • • • • •				
		new evaluation." At the				
		ssment, a narrative stated,				
		rding limitations to left				
	shoulder and w	ound care dressings."				
	b. A clinic	al document dated 10/4/11				
	titled "Skilled N	Nursing Assessment -				
		ned by patient #11 and				
	Ũ	N, under patient caregiver				
		ed, "Wound care done."				
		nd section of this				
		nurse stated, "Site left				
		nuise stated, she left				1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	Ĩ,	ILDING NG	NSTRUCTION 00	COMPLET 01/12/20	
	PROVIDER OR SUPPLIEF			1947 HA	ADDRESS, CITY, STATE, ZIP ARDER CT STE B ERVILLE, IN 46375	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL I LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPI	
		with normal saline, n-adherent dressing, and e."					
	"Resumption of Stay" dated 10/1 Employee H stat medication with under right breas powder after bat D. On 1/11/ administrator inc	al document titled Care following Inpatient 3/11 and signed by ted, "Teachings regarding small excoriated area st note of apply medicated hing." /11 at 3:50 PM, the dicated no wound care or edicated powder were					
	<ul> <li>4. The agency p</li> <li>Care with no eff</li> <li>plan of care showed and the patient, and with the patient, interdisciplinary</li> </ul>	POC. policy titled Patient Plan of ective date stated, "The ald be developed, ad revised in coordination the physician, and the team members involved are, in accordance with					

## 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 COMPLETED 00 . BUILDING 157581 01/12/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 (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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG N0606 Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and N0606 make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. The alternate administrator 01/27/2012 Based on clinical record review and in-serviced all skilled nurses and policy review and interview, the agency home health aides that a failed to ensure the registered nurse made supervisory visit must be done on-site visits to the patient's home no less every 2 weeks and an on-site visit frequently than every 2 weeks for 3 of 8 with the HHA be done every 30 days. Home health aide clinical records reviewed of patients with supervision policy was skilled and home health aide services. reinforced. The field nursing (Clinical records #1, #2, and #11). supervisor will monitor frequency of HHA visits for accuracy and completeness. 10% of clinical Findings records will be audited quarterly to ensure home health aide 1. Clinical record #1 included a plan of supervision visits were performed care (POC) for the certification period according to policy. Administrator will be responsible for monitoring 10/11/11 - 12/9/11 with orders for home compliance to ensure this health aide services two times a week for deficiency is corrected and will 8 weeks and 1 times a week for 1 week. not reoccur. The record failed to evidence any supervisory visits from 10/11/11 - 12/9/11 despite aide visits which occurred as ordered on the POC. 2. Clinical record #2 included a POC for the certification period 12/20/11 - 2/17/12with orders for home health aide services three times a week for two weeks and two times a week for seven weeks. The record failed to evidence any supervisory visits

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Facility ID: 011121

If continua

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157581	Ì,	JILDING NG	00	(X3) DATE SURVEY COMPLETED 01/12/2012	
	PROVIDER OR SUPPLIEI			1947 H	ADDRESS, CITY, STATE, ZIP COD ARDER CT STE B ERVILLE, IN 46375	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE
		nrough 1/12/12 despite n occurred as ordered on					
	the certification with orders for h two times a wee record failed to visits made duri	rd #11 included a POC for period 9/30/11 - 11/28/11 nome health aide services k times 8 weeks. The evidence any supervisory ng this time despite aide urred as ordered on the					
		t 3:15 PM, the dicated no supervisory enced in these clinical					
	Aide Supervisio stated, "Supervisio clients by registe supervisor to ass services are bein with the plan of The registered n aide supervisory least every two aide is present to when the aide al	policy titled "Home Health n" with no effective date sor visits are made to ered nurses and the nurse sure that home health aide ng provided in accordance care and Agency policy urse makes a home health visit to the patient at weeks, either when the pobserve and assist, or osent, to assess the determine whether goals					

## 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 COMPLETED 00 . BUILDING 157581 01/12/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1947 HARDER CT STE B ASSURED HOME HEALTHCARE INC SCHERERVILLE. IN 46375 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 PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG N0608 Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional N0608 standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. The alternate administrator Based on clinical record and policy 01/27/2012 in-serviced all staff regarding review and interview, the agency failed to documenting corrections in the ensure clinical records were maintained clinical records. Clinical data per agency policy for 1 of 12 records collection policy was reinforced. 10% of clinical records will be reviewed (Clinical record #8). audited to ensure clinical records with errors are corrected per Findings policy. Administrator will be responsible for monitoring 1. Clinical record #8, start of care compliance to ensure this deficiency will not reoccur. 9/26/11, evidenced documents with dates altered on the following clinical documents: a. The clinical document titled "HCFA [Health Care Financing Administration] Medical Information Release Authorization" signed by the patient with a date of 9/26/11 and signed by Employee State Form Event ID: TRZ911 Facility ID: 011121 If continuation sheet Page 50 of 53

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			COMP	(X3) DATE SURVEY COMPLETED	
		157581	B. WI	NG		01/12	01/12/2012	
NAME OF	PROVIDER OR SUPPLIE	P	-	STREET A	DDRESS, CITY, STATE, ZIP CODI	E		
					ARDER CT STE B			
ASSURI	ED HOME HEALTH	ICARE INC		SCHER	ERVILLE, IN 46375			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECT	FION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
		59/26/11. Both dates had						
	been altered wi	th the "6" written over						
	another number	The other number						
	written below the	his superimposed number						
	could no longer	be read.						
	h The clinical	document titled						
	"Admission Checklist" with patient #8's							
		of $9/26/11$ . This date had						
		th the "6" written over						
		mber now illegible. The						
		_						
		evidenced referral form						
	-	: 9/26/11 and date received						
		ian telephone and other						
	verbal orders date completed: 9/26/11 and							
		26/11, patient's rights and						
	-	date completed 9/26/11,						
	advance directi	ves date completed						
	9/26/11, initial discharge plan date							
	completed 9/26/11. Each "6" had been							
	written over with another number now							
	illegible.							
	c. The clinical	document titled "Medicare						
	Questionnaire"							
		written date of $9/26/11$ and						
	-	ignature with the written						
		Each "6" in the written						
		nature of the patient and						
	-	the employee had been						
		other number now						
	illegible.							
	d. The clinical	document titled "Patient						

STATEME	TERS FOR MEDICARE & MEDICAID SERVICES         TATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       X2) MULTIPLE CONSTRUCTION						OMB NO. 0938-03 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER: 157581	A. BUILDING 00 B. WING				COMPLETED 01/12/2012		
NAME OF	PROVIDER OR SUPPLIEF	ł			ADDRESS, CITY, STATE, ZIP	CODE			
ASSUR	ED HOME HEALTH	CARE INC			ARDER CT STE B RERVILLE, IN 46375				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
	Rights and Resp patient #8's nam the beginning of and responsibilit At the end of the signature and the Employee F's sig 9/26/11. Each "/ the signature of signature of the written over with illegible. e. The clinical of Regimen Review and a list of all t with the start dat this date has bee another number F's signature is w box. f. The clinical of Care version" w 9/26/11 and date 9/28/11. The "6 written over with illegible. This d signature of the Employee F's sig 9/28/11. Each "/	onsibilities" with the e and date of 9/26/11 at the listed patient rights ties. The rights follow. e document, the patient e date of 9/26/11 and gnature with date of 6" in the written dates by the patient and the employee had been in another number now locument titled "Drug w" with the patient name he patient's medications te of 9/26/11. The "6" in n written over with now illegible. Employee written in the signature document titled "Start of ith the start of care date of e assessment completed of " and "8" have been in other numbers now ocument ends with the patient on 9/28/11 and gnature also signed on 6" in the written dates by the patient and the employee had been in another number now							

	R MEDICARE & MEDIC						OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00			COMPLETED	
		157581	B. WI	NG		- 01/	01/12/2012	
NAME OF	PROVIDER OR SUPPLIEF	-	4		DDRESS, CITY, STATE, ZIP	CODE		
					ARDER CT STE B			
ASSURE	ED HOME HEALTH	CARE INC		SCHER	ERVILLE, IN 46375			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	illegible.							
	2. On 1/12/12 a	-						
		dicated the numbers had						
	been altered and	not corrected per agency						
	policy.							
	3. The agency p	-						
		e data collection" with a						
		f C:2-033.1 with a						
		May 2010 stated, "Errors						
	in documentation will be corrected as							
	follows: Draw a	line through the entry,						
		Do not erase, use						
	correction fluid	or deface a document."						
	1						1	