

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000 Bldg. 00	<p>This was a Federal home health recertification survey.</p> <p>This was a partially extended survey.</p> <p>Survey Dates: April 7, 8 and 9, 2015</p> <p>Facility #: IN007135</p> <p>Medicaid Vendor #: 157605</p> <p>Unduplicated 12 month census: 61 Active Patients: 12</p> <p>QA:JE 4-20-15</p>	G 000		
G 110 Bldg. 00	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation, clinical record</p>	G 110	G0110 The Administrator	04/10/2015

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 13 of 13 clinical records (#s 1-13).</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The undated admission book given to the patients failed to include an updated July 2013, version of the 2004 Indiana Advanced Directives document in the admission folder that was distributed to the patients at the start of care. 2. On 4/9/15 at 9:45 AM, Employee A, administrator, acknowledged the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013). 3. During home visit observation of patient's (#4, 5, and 6) home folder did not contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives. <ul style="list-style-type: none"> A. Home Visit observation on 4/8/15 at 11:00 AM with patient #4, start of care (SOC) 12/2/14, the home folder contained unrevised, May 2004 copy of the Indiana Advanced Directives. 		<p>downloaded the current Advance Directives information from the ISDH website and placed it in the admission folders for future patients. All current patients also received the current Advance Directives information. The Administrator will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>B. Home Visit observation on 4/8/15 at 12:15 PM with patient #6, SOC 8/18/14, home folder contained unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>C. Home Visit observation on 4/8/15 at 1:30 PM, with patient #5, SOC 8/8/14, home folder contained unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>4. Clinical record #1, SOC 7/9/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>5. Clinical record #2, SOC 12/26/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>6. Clinical record #3, SOC 7/11/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7. Clinical record #4, SOC 12/2/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>8. Clinical record #5, SOC 8/8/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>9. Clinical record #6, SOC 8/18/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>10. Clinical record #7, SOC 3/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>11. Clinical record #8, SOC 7/15/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12. Clinical record #9, SOC 12/11/09, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.			
	13. Clinical record #10, SOC 3/4/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.			
	14. Clinical record 11, SOC 4/29/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.			
	15. Clinical record #12, SOC 12/18/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.			
	16. Clinical record #13, SOC 6/12/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 152 Bldg. 00	<p>date.</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines. Based on administrative record and agency policy review and interview, the agency failed to ensure a group of professional personnel (PAC) was formed and met quarterly that included representation of a physician, registered nurse (RN), and other disciplines that provided services on behalf of the agency for 2 of 2 months of meeting minutes reviewed. (December 2013 and 2014)</p> <p>Findings</p> <p>1. The agency's administrative records included a document titled" FIRST CHOICE HOME HEALTH SERVICE, INC. PROFESSIONAL ADVISORY COMMITTEE MEETING AGENDA DECEMBER 30, 2014 ." The document failed to evidence an appropriate representative from other disciplines was in attendance at the meeting.</p>	G 152	G0152 The Administrator appointed a physical therapist and a community member to the PAC. These positions will be permanently filled. The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	04/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 153 Bldg. 00	<p>2. The agency's administrative records included a document titled" FIRST CHOICE HOME HEALTH SERVICE, INC. PROFESSIONAL ADVISORY COMMITTEE MEETING AGENDA DECEMBER 30, 2013 ." The document failed to evidence an appropriate representative from other disciplines was in attendance at the meeting.</p> <p>3. On 4/9/15 at 1:35 PM, Employee A, administrator, acknowledged that only the medical director, employee A, administrator, and employee B, alternate administrator where in attendance for these meetings and that an appropriate representative from other disciplines was not in attendance.</p> <p>4. The agency policy titled "Professional Advisory Committee" with no date, states, " ... SPECIAL INSTRUCTIONS 1. The governing body or administrator appoints a committee that must include at least one physician, one registered nurse and appropriate representative from other disciplines, community groups and consumers"</p> <p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.</p> <p>Based on administrative record, agency policy review and interview, the agency failed to ensure a group of professional personnel (PAC) was formed and met quarterly that included representation of a physician, registered nurse (RN), other disciplines that provided services on behalf of the agency, and community groups and consumers for 2 of 2 months of meeting minutes reviewed. (December 2013 and 2014)</p> <p>Findings</p> <p>1. The agency's administrative records included a document titled " FIRST CHOICE HOME HEALTH SERVICE, INC. PROFESSIONAL ADVISORY COMMITTEE MEETING AGENDA DECEMBER 30, 2014 ", The document failed to show an appropriate representative for a community member/consumer was in attendance at the meeting.</p> <p>2. The agency's administrative records included a document titled " FIRST</p>	G 153	G0153 The Administrator appointed a physical therapist and a community member to the PAC. These positions will be permanently filled. The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	04/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 176 Bldg. 00	<p>CHOICE HOME HEALTH SERVICE, INC. PROFESSIONAL ADVISORY COMMITTEE MEETING AGENDA DECEMBER 30, 2013 ", The document failed to show an appropriate representative for a community member/consumer was in attendance at the meeting was in attendance at the meeting.</p> <p>3. On 4/9/15 at 1:35 PM, Employee A, administrator, acknowledged that only the medical director, employee A, administrator, and employee B, alternate administrator where in attendance for these meetings and that an appropriate representative from other disciplines was not in attendance.</p> <p>4. The agency policy titled "Professional Advisory Committee" with no date, states, " ... SPECIAL INSTRUCTIONS 1. The governing body or administrator appoints a committee that must include at least one physician, one registered nurse and appropriate representative from other disciplines, community groups and consumers"</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure care was provided and documented by the Registered Nurse (RN), employee C, as ordered on the plan of care (POC) for 6 (#3, 4, 5, 10,11, and #12) of 13 clinical records reviewed.</p> <p>Findings:</p> <p>1. Clinical record #3, start of care (SOC) 7/11/14, included a plan of care for the certification period, 3/8/15-5/6/15. The plan of care (POC) states, " skilled nurse observation / assessments/ evaluation / monitoring with each visit: vital signs ... cardiopulmonary status ... " Skilled nurse visit notes dated, 3/13/15 and 3/21/15, have incomplete documentation of (pedal edema and pedal pulses blank) cardiopulmonary assessments.</p> <p>Interview on 4/9/15 at 2:55 PM, the administrator, employee A and alternate administrator, employee B agreed that employee C, RN, did not complete cardiopulmonary assessment on skilled nurse visit notes dated 3/13/15 and 3/21/15 for patient #3.</p>	G 176	G0176 Employee C was individually inserviced on 4/10/15 regarding clinical documentation and following the plan of care by the Asst. Administrator. A clinical documentation inservice for all staff was provided by the Asst. Administrator and the Adminstrator on 4/29/15 related to following the plan of care accurately and completely. Staff will be responsible for completing visit notes accurately with 100% compliance with the plan of care. Visit notes will be monitored by the Asst. Administrator the and Administrator weely. The Administrator will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.	04/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Clinical record #4, SOC 12/2/14, included a plan of care for the certification period, 1/31/15-3/31/15 and 4/1/15-5/30/15 that stated, "skilled nurse observation / assessment / evaluation / monitoring with each visit: vital signs ... cardiopulmonary status ... " Skilled nurse visit notes dated, 2/1/15, 2/11/15, 2/18/15, 2/27/15, 3/4/15, 3/11/15, and 3/25/15, have incomplete documentation of (pedal edema and pedal pulses blank) cardiopulmonary assessments.</p> <p>Interview on 4/9/15 at 1:00 PM, the administrator, employee A, and alternate administrator, employee B agreed that employee C, RN, did not complete cardiopulmonary assessment on skilled nurse visit notes dated 2/1/15, 2/11/15, 2/18/15, 2/27/15, 3/4/15, 3/11/15, and 3/25/15 for patient #4.</p> <p>3. Clinical record #5, SOC 8/7/14, included a plan of care for the certification periods 2/3/15-4/3/15 and 4/4/15-6/2/15 that state, "skilled nurse observation / assessments / evaluation / monitoring with each visit: vital signs ... cardiopulmonary status ... " Skilled nurse visit notes dated, 2/11/15, 2/18/15, 3/4/15, 3/11/15, 3/18/15, and 3/25/15, have incomplete documentation of (pedal edema and pedal pulses blank) cardiopulmonary assessments.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

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

	<p>Interview on 4/9/15 at 12:55 PM, the administrator, employee A, and alternate administrator, employee B, agreed that employee C, RN, did not complete cardiopulmonary assessment on skilled nurse visit notes dated 2/11/15, 2/18/15, 3/4/15, 3/11/15, 3/18/15 and 3/25/15 for patient #5.</p> <p>4. Clinical record #10, SOC 3/4/15, included a plan of care for the certification period, 3/4/15-5/2/15 that states, "skilled nurse observation / assessments / evaluation / monitoring with each visit: vital signs, pain, s/s of infection, medications, mental status, neurological status, cardiopulmonary status, muscular/skeletal, GI/GU status ... wound status, hydration/nutrition/elimination, weight," In skilled nurse visit notes dated 3/25/15, employee C, RN, failed to document patient's mental status, temperature and pulse, regularity of respirations, patients weight, breath sounds, cardiopulmonary status, neuromuscular status, wound/ostomy care, gastrointestinal assessment, and genitourinary assessment findings.</p> <p>Interview on 4/9/15 at 1:15 PM, the administrator, employee A, and alternate administrator, employee B, agreed that</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>employee C, RN, failed to document, patient's mental status, location of temperature and pulse, regularity of respirations, patients weight, breath sounds, cardiopulmonary status, neuromuscular status, wound/ostomy care, gastrointestinal assesses, and genitourinary assessment findings for patient #10.</p> <p>5. Clinical record #11, SOC 4/29/14, included a plan of care for the certification period, 2/23/15-4/23/15 that states, "skilled nurse observation / assessments / evaluation monitoring with each visit: vital signs, pain, s/s of infection, medications, mental status, neurological status, cardiopulmonary status, muscular/skeletal status, GI/GU status ... wound status, hydration/nutrition/elimination ... Perform pulse oximetry: every visit and PRN dyspnea"</p> <p>A. The skilled nurse visit note dated 3/10/15, employee C, RN, failed to document a complete cardiopulmonary assessment, neuromuscular assessment, and pulse oximetry findings.</p> <p>B. The skilled nurse visit note dated 3/17/15, employee C, RN, failed to document complete cardiopulmonary assessment, neuromuscular assessment,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and wound/ostomy care assessment.</p> <p>Interview on 4/9/15 at 1:15 PM, the administrator, employee A, and alternate administrator, employee B, agreed that employee C, RN, did not complete all areas of assessment on skilled nurse visit notes dated 3/10/15 and 3/17/15 for patient #11.</p> <p>6. Clinical record #12, SOC 12/18/14, included a plan of care for the certification period 2/16/15-4/16/15 that states, "skilled nurse observation / assessments / evaluation monitoring with each visit: vital signs, pain, s/s of infection, medications, mental status, neurological status, cardiopulmonary status, muscular/skeletal, GI/GU status ... wound status, hydration/nutrition/elimination ... Diabetic care ... foot/skin care"</p> <p>A. In skilled nurse visit notes dated, 2/16/15, 2/23/15, and 3/13/15, employee C failed to document a complete cardiopulmonary assessment, neuromuscular assessment, and wound/ostomy care assessment.</p> <p>B. In skilled nurse visit notes dated 2/20/15, 2/27/15, 3/2/15, 3/5/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15, and 3/30/15, employee C failed to document a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000 Bldg. 00	<p>complete cardiopulmonary and neuromuscular assessment.</p> <p>C. Interview on 4/9/15 at 1:10 PM, the administrator, employee A and alternate administrator, employee B, agreed that employee C, RN did not complete all areas of assessment on skilled nurse visit notes dated 2/16/15, 2/20/15, 2/23/15, 2/27/15, 3/2/15, 3/5/15, 3/9/15, 3/13/15, 3/16/15, 3/20/15, 3/23/15, and 3/30/15 for patient #12.</p> <p>7. Agency's policy titled "Clinical Documentation", with no date, states, "PURPOSE ... To document conformance with the Plan of Care ... SPECIAL INSTRUCTIONS 1. All skilled services provided by nursing ... will be documented in the clinical record ... 5. Documentation of services ordered on the plan of care will be completed the day service is rendered"</p> <p>This was a State re-licensure home health survey.</p> <p>Survey Dates: April 7, 8, and 9, 2015</p>	N 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 518 Bldg. 00	<p>Facility #: IN007135</p> <p>Medicaid Vendor #: 157605</p> <p>Unduplicated 12 month census: 61 Active Patients: 12</p> <p>QA:JE 4-20-15</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation, clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 13 of 13 clinical records (#s 1-13).</p> <p>Findings include</p> <p>1. The undated admission book given to the patients failed to include an updated July 2013, version of the 2004 Indiana Advanced Directives document in the</p>	N 518	N0518 The Administrator downloaded the current Advance Directives information from the ISDH website and placed it in the admission folders for future patients. All current patients also received the current Advance Directives information. The Administrator will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.	04/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>admission folder that was distributed to the patients at the start of care.</p> <p>2. On 4/9/15 at 9:45 AM, Employee A, administrator, acknowledged the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. During home visit observation of patient's (#4, 5, and 6) home folder did not contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives.</p> <p>A. Home Visit observation on 4/8/15 at 11:00 AM with patient #4, start of care (SOC) 12/2/14, the home folder contained unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>B. Home Visit observation on 4/8/15 at 12:15 PM with patient #6, SOC 8/18/14, home folder contained unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>C. Home Visit observation on 4/8/15 at 1:30 PM, with patient #5, SOC 8/8/14, home folder contained unrevised, May 2004 copy of the Indiana Advanced Directives.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4. Clinical record #1, SOC 7/9/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>5. Clinical record #2, SOC 12/26/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>6. Clinical record #3, SOC 7/11/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>7. Clinical record #4, SOC 12/2/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>8. Clinical record #5, SOC 8/8/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>9. Clinical record #6, SOC 8/18/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>10. Clinical record #7, SOC 3/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>11. Clinical record #8, SOC 7/15/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>12. Clinical record #9, SOC 12/11/09, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>13. Clinical record #10, SOC 3/4/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/09/2015	
NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N 544 Bldg. 00	<p>date.</p> <p>14. Clinical record 11, SOC 4/29/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>15. Clinical record #12, SOC 12/18/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>16. Clinical record #13, SOC 6/12/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed the document was received on the SOC date.</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on clinical record review, policy review, and interview, the agency failed to ensure care was provided and documented by the Registered Nurse</p>	N 544	N0544 Employee C was individually inserviced on 4/10/15 regarding clinical documentation and following the plan of care by the Asst. Administrator. A clinical	04/29/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(RN), employee C, as ordered on the plan of care (POC) for 6 (#3, 4, 5, 10,11, and #12) of 13 clinical records reviewed.</p> <p>Findings:</p> <p>1. Clinical record #3, start of care (SOC) 7/11/14, included a plan of care for the certification period, 3/8/15-5/6/15. The plan of care (POC) states, " skilled nurse observation / assessments/ evaluation / monitoring with each visit: vital signs ... cardiopulmonary status ... " Skilled nurse visit notes dated, 3/13/15 and 3/21/15, have incomplete documentation of (pedal edema and pedal pulses blank) cardiopulmonary assessments.</p> <p>Interview on 4/9/15 at 2:55 PM, the administrator, employee A and alternate administrator, employee B agreed that employee C, RN, did not complete cardiopulmonary assessment on skilled nurse visit notes dated 3/13/15 and 3/21/15 for patient #3.</p> <p>2. Clinical record #4, SOC 12/2/14, included a plan of care for the certification period, 1/31/15-3/31/15 and 4/1/15-5/30/15 that stated, "skilled nurse observation / assessment / evaluation / monitoring with each visit: vital signs ... cardiopulmonary status ... " Skilled nurse visit notes dated, 2/1/15, 2/11/15,</p>		<p>documentation inservice for all staff was provided by the Asst. Administrator and the Administrator on 4/29/15 related to following the plan of care accurately and completely. Staff will be responsible for completing visit notes accurately with 100% compliance with the plan of care. Visit notes will be monitored by the Asst. Administrator and the Administrator weekly. The Administrator will be responsible for monitoring this corrective action to ensure this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2/18/15, 2/27/15, 3/4/15, 3/11/15, and 3/25/15, have incomplete documentation of (pedal edema and pedal pulses blank) cardiopulmonary assessments.</p> <p>Interview on 4/9/15 at 1:00 PM, the administrator, employee A, and alternate administrator, employee B agreed that employee C, RN, did not complete cardiopulmonary assessment on skilled nurse visit notes dated 2/1/15, 2/11/15, 2/18/15, 2/27/15, 3/4/15, 3/11/15, and 3/25/15 for patient #4.</p> <p>3. Clinical record #5, SOC 8/7/14, included a plan of care for the certification periods 2/3/15-4/3/15 and 4/4/15-6/2/15 that state, "skilled nurse observation / assessments / evaluation / monitoring with each visit: vital signs ... cardiopulmonary status ... " Skilled nurse visit notes dated, 2/11/15, 2/18/15, 3/4/15, 3/11/15, 3/18/15, and 3/25/15, have incomplete documentation of (pedal edema and pedal pulses blank) cardiopulmonary assessments.</p> <p>Interview on 4/9/15 at 12:55 PM, the administrator, employee A, and alternate administrator, employee B, agreed that employee C, RN, did not complete cardiopulmonary assessment on skilled nurse visit notes dated 2/11/15, 2/18/15, 3/4/15, 3/11/15, 3/18/15 and 3/25/15 for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient #5.</p> <p>4. Clinical record #10, SOC 3/4/15, included a plan of care for the certification period, 3/4/15-5/2/15 that states, "skilled nurse observation / assessments / evaluation / monitoring with each visit: vital signs, pain, s/s of infection, medications, mental status, neurological status, cardiopulmonary status, muscular/skeletal, GI/GU status ... wound status, hydration/nutrition/elimination, weight," In skilled nurse visit notes dated 3/25/15, employee C, RN, failed to document patient's mental status, temperature and pulse, regularity of respirations, patients weight, breath sounds, cardiopulmonary status, neuromuscular status, wound/ostomy care, gastrointestinal assessment, and genitourinary assessment findings.</p> <p>Interview on 4/9/15 at 1:15 PM, the administrator, employee A, and alternate administrator, employee B, agreed that employee C, RN, failed to document, patient's mental status, location of temperature and pulse, regularity of respirations, patients weight, breath sounds, cardiopulmonary status, neuromuscular status, wound/ostomy care, gastrointestinal assesses, and genitourinary assessment findings for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient #10.</p> <p>5. Clinical record #11, SOC 4/29/14, included a plan of care for the certification period, 2/23/15-4/23/15 that states, "skilled nurse observation / assessments / evaluation monitoring with each visit: vital signs, pain, s/s of infection, medications, mental status, neurological status, cardiopulmonary status, muscular/skeletal status, GI/GU status ... wound status, hydration/nutrition/elimination ... Perform pulse oximetry: every visit and PRN dyspnea"</p> <p>A. The skilled nurse visit note dated 3/10/15, employee C, RN, failed to document a complete cardiopulmonary assessment, neuromuscular assessment, and pulse oximetry findings.</p> <p>B. The skilled nurse visit note dated 3/17/15, employee C, RN, failed to document complete cardiopulmonary assessment, neuromuscular assessment, and wound/ostomy care assessment.</p> <p>Interview on 4/9/15 at 1:15 PM, the administrator, employee A, and alternate administrator, employee B, agreed that employee C, RN, did not complete all areas of assessment on skilled nurse visit notes dated 3/10/15 and 3/17/15 for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient #11.</p> <p>6. Clinical record #12, SOC 12/18/14, included a plan of care for the certification period 2/16/15-4/16/15 that states, "skilled nurse observation / assessments / evaluation monitoring with each visit: vital signs, pain, s/s of infection, medications, mental status, neurological status, cardiopulmonary status, muscular/skeletal, GI/GU status ... wound status, hydration/nutrition/elimination ... Diabetic care ... foot/skin care ... "</p> <p>A. In skilled nurse visit notes dated, 2/16/15, 2/23/15, and 3/13/15, employee C failed to document a complete cardiopulmonary assessment, neuromuscular assessment, and wound/ostomy care assessment.</p> <p>B. In skilled nurse visit notes dated 2/20/15, 2/27/15, 3/2/15, 3/5/15, 3/9/15, 3/16/15, 3/20/15, 3/23/15, and 3/30/15, employee C failed to document a complete cardiopulmonary and neuromuscular assessment.</p> <p>C. Interview on 4/9/15 at 1:10 PM, the administrator, employee A and alternate administrator, employee B, agreed that employee C, RN did not complete all areas of assessment on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157605	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRST CHOICE HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6 N MORGAN BLVD STE 101 VALPARAISO, IN 46383
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>skilled nurse visit notes dated 2/16/15, 2/20/15, 2/23/15, 2/27/15, 3/2/15, 3/5/15, 3/9/15, 3/13/15, 3/16/15, 3/20/15, 3/23/15, and 3/30/15 for patient #12.</p> <p>7. Agency's policy titled "Clinical Documentation", with no date, states, "PURPOSE ... To document conformance with the Plan of Care ... SPECIAL INSTRUCTIONS 1. All skilled services provided by nursing ... will be documented in the clinical record ... 5. Documentation of services ordered on the plan of care will be completed the day service is rendered"</p>			